

BACCALAUREATE NURSING STUDENTS' EXPERIENCE OF LEARNING
IN A CLINICAL SETTING

By

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A major component of basic nursing educational programs takes place in a clinical practice setting. Little research has been reported on the ways that students learn in a clinical setting. The purpose of this study was to explore and describe nursing students' experience of learning within the context of one clinical practice setting where the students learned to provide care for acutely ill infants. Learning was approached as a process that takes place in a complex social context and that is affected by the interaction between the students and all of the contextual variables. Data collected using the techniques of participant observation and ethnographic interviewing were analyzed to identify the components of the nursing students' experience of learning in a clinical setting.

The findings of the study included a nursing student perspective of learning in a clinical setting and a sequence of steps in the process of learning a clinical skill. The effect of the nursing student perspective on the learning process was also described.

The nursing student perspective consisted of six goals—to do no harm to a patient, to help patients, to integrate theory-based knowledge from lecture and reading into clinical practice, to learn clinical practice skills, to look good as a student, and to look good as a nurse. Within this perspective the students also defined roles for themselves, their instructors, and the staff nurses in the clinical setting.

The process of learning a clinical skill consisted of observing, rehearsing, doing, and evaluating. The nursing student perspective affected this learning process by determining students' choices about each step.

The steps of learning a clinical skill contrast with the nursing student perspective were consistent with the components of observational learning in Albert Bandura's social learning theory. The nursing student perspective and the effects of that perspective also reflected the social interactional nature of modeling identified with symbolic interactionism. The students defined the learning environment and then used that definition to shape their responses to the educational program.

CHAPTER ONE

Introduction

Background and Context of the Study

The process of becoming a professional nurse involves a program of study that includes both classroom instruction and supervised clinical practice. Until the second half of this century nursing practice skills were usually learned by total immersion in a nursing service setting, often without adequate instructor or staff supervision. As nursing schools moved away from the hospital model and toward the university model there was a distinct change in the character of student clinical practice. The number of hours that a student spent in the practice setting decreased, and the specific purpose of clinical practice was to learn how to provide nursing care; this learning experience only incidentally provided care for patients.

Today new nurse students in the clinical area for much shorter time periods although the scope of nursing practice has greatly enlarged, and students today have much more to learn than their counterparts twenty years ago. Although faculty are expected to teach students more skills in less time, little is known about the ways students learn in a clinical practice setting. There is no theoretical framework for explaining the process of learning in the clinical area that can be translated into instructional models.

Clinical teaching is often based on content (what the faculty thinks the student ought to know) rather than on knowledge of the ways in which students learn. Students are evaluated on how well they transfer knowledge acquired in the classroom setting to the clinical practice experience, but the most effective way to facilitate this transfer has not been established through research on learning. Much has been written in nursing education about the importance of role modeling by faculty (Cline, 1973; Fraser, 1968, 1970; Bagen, 1974). Nursing curricula have been developed with the concept of faculty role modeling as a foundation for student learning. However, the assumptions underlying this nursing education framework have not been validated by research into the process of student learning in the clinical area.

Initial interest in this study was prompted by a search for a theory of learning that explained what was happening in clinical nursing education. Bandura's (1977) social learning theory may explain part of what happens, but a search of the literature produced no description of the actual learning process in the context of a health care agency.

Erickson (1960) reported a review of the literature in anthropology on taught cognitive learning (instruction with deliberate and intentional aims for the content of learning). He found that there has been very little work done on the content and processes of taught cognitive learning, the processes of learning by individuals, or on the acquisition of consciously held knowledge, skills, and ways of thinking. He suggested that researchers need to shift from a study

of group learning is the study of individual learning in a social context.

Spindler and Spindler (1982) noted that few anthropologists made use of the work of learning theorists and that they were overlooking a valuable resource. These authors have found Bandura's (1977) social learning theory to be a useful theoretical model in anthropological research because of its emphasis on both the processes and the results of learning. Social learning theory, like anthropology, is concerned with the circumstances of learning.

Statement of the Problem

All learning takes place within a social context. However, clinical education in nursing occurs in a complex social context that includes many more variables than the traditional academic setting. Most of the research on learning has been conducted in the classroom or in a laboratory setting. How do the contextual variables alter the learning process and the students' experience of that process? The purpose of this study was to explore and describe nursing students' experience of learning within the context of one clinical practice setting where the students learned to provide nursing care for acutely ill infants.

Research Questions

The broad general question posed for this study was: What kinds of experiences and behavior are part of the process of learning

clinical skills in a clinical setting with acutely ill infants? Additional questions which provided the initial structure for the study were:

1. What sources of information do students draw on to learn clinical skill/s?
2. How do students structure their learning?
3. What factors in the clinical setting affect student learning?
4. In what ways is the process of learning the same for all students?
5. What are the differences, if any, between the students and instructors?
6. What kinds of learning occur in the clinical setting?
7. What are the underlying rules which govern learning behavior in the clinical area?
8. What functions do the students' clinical behavior serve?
9. What are the contexts in which learning occurs?

Significance of the Study

With the limitations on time for student clinical experience and the growing complexity of health care, an understanding of the process of learning in a clinical setting could lead to instructional models which would enable faculty and students to make more effective use of valuable clinical time. Faculty members place students in clinical practice sites in order to achieve particular learning objectives, but frequently they have no theoretical model for planning learning

experiences that will facilitate achievement of these objectives. A description of the learning process may lead to development of a theoretical model for learning and thus instructional models which will facilitate learning.

In much of the research in nursing education, investigators have examined the characteristics of successful students and how their values and attitudes toward nursing evolved during their professional education. Researchers have looked at entry and exit conditions but have not examined the process that created the difference between entry and exit characteristics. Little has been done to establish a theoretical base for understanding the process of learning in nursing clinical education.

Each year approximately 1800 students enroll in one of the associate degree or generic baccalaureate nursing programs in the state of Florida. The faculty and students of these thirty programs, and the people of Florida, will benefit from a better understanding of the way clinical practice skills are learned.

Design of the Study

After receiving approval from the hospital nursing service administrator and the College of Nursing, the researcher conducted 26 hours of observation of nursing students engaged in a clinical practice experience with acutely ill infants. Observations began during the first week in February 1984 and continued through the last week in July 1984 with the exception of scheduled breaks in the academic calendar. These observations of 40 infants were conducted

during a sampling of all days and hours of the scheduled clinical practice times. Analysis of data from early observations was used to formulate initial questions for use in interviews of the observed nursing students which were conducted beginning with the fifth week of the study period and continued throughout the remainder of the study period.

Data analysis was conducted throughout the study using the techniques described by Israel (1979, 1980). The steps of data analysis included making a domain analysis, making a taxonomic analysis, making a conceptual analysis, and discovering cultural themes. The domains and taxonomies that were constructed to organize the data reflected the nursing students' experience of learning in a clinical setting.

Scope of the Study

The study was conducted in one room of a pediatric hospital unit where students from a generic baccalaureate nursing program had clinical practice with acutely ill infants and was focused on the clinical practice and learning behaviors of the 48 students who had clinical practice assignments in this room from February 1984 through July 1984. This study was restricted to a brief report of each individual student's clinical practice experience. Had the study been conducted in a different clinical setting, different findings may have resulted due to the differing contextual variables. The results of this study can be used to provide insight into the nursing students' experience of learning in a clinical setting.

CHAPTER TWO

REVIEW OF THE LITERATURE

In the process of becoming a professional nurse, each nursing student acquires a specialized body of knowledge and skills and a set of values and attitudes toward the profession. While this learning process does not cease with graduation, it is within the context of the undergraduate generic nursing education program that basic knowledge and skills are acquired and the process of professional socialization begins. A large portion of this learning process occurs in the clinical setting. A student in a typical upper division baccalaureate degree nursing program spends 12 to 15 hours each week working in a clinical setting. A significant portion of the research in nursing education has been focused on this process of professional socialization.

Professional Socialization

Both sociologists and nurses have studied the process of professional socialization. Jussa (1973) defines professional socialization as that complex process by which an individual acquires the knowledge, skills, and sense of occupational identity that characterize members of that profession. Much of the early work on professional socialization was focused on what were, at that time, all male professions. Students in medicine, law, and the military have

been studied extensively (Becker, Geer, Hughes, & Strauss, 1961; Becker & Stelling, 1977; Gendreau, 1988; Lortie, 1983; Marton, Isager, & Koppell, 1987). Professional schools were described as creating a social environment which facilitated the acquisition of the professional identity expected of the graduate. These studies were focused on progress toward the end product of professional identity. Acquiring the knowledge and skills required for a given profession was described as a necessary part of this process, but studies of the actual learning processes have not been reported. The focus has been on that part of the socialization process that involves the acquisition of the attitudes, values, and identity of the profession.

Becker et al. (1961) described medical school as the longest rite of passage in the Western world. Findings of Becker's longitudinal observational study of medical students were that the transition from Tyroes to skilled, confident physician was a slow, laborious process, and that the focus of the students was on being and surviving as students rather than the end result of this socialization process. The authors described a student culture in which students assessed faculty requirements, selected certain strategies, and behaved in ways they believed would satisfy faculty demands. By observing various students in their daily activities and by conducting many interviews with both students and faculty over a four year period, these authors constructed a comprehensive picture of medical education from a student perspective.

In a more recent study, Becker and Stelling (1977) investigated four groups of postgraduate students: students in two very different psychiatric residencies, students in an internal medicine residency,

and students in biochemistry. Role-taking, the trying on of a role, was found to be of critical importance in the development of that professional identity essential to effective professional socialization. Through this role-taking, the student achieved a sense of mastery of the essential skills and knowledge of the field. Barker and Stalling found that the particular skills and knowledge that the student worked to master were determined by what the student saw the professionals around him doing. In other studies of medical students and residents, the importance of teachers as role models in the process of professional socialization was described (Balkman & Platts, 1966; Barker, 1981).

Professional Socialization in nursing

In *The Silent Dialogue*, Eisen and Whitaker (1988) recorded the progress of young, American, white class women through the three years of a new, innovative baccalaureate degree nursing program. In Barker's study, the emphasis was on the student culture. The process that was described by Eisen and Whitaker enabled the students to emerge at the completion of the program with a set of attitudes and values that made up their professional identity. Again, the process of learning knowledge and skills was assumed but not described.

Gabrick (1976) investigated professional socialization as a function of the consistency of values and attitudes among the professional role models encountered during the educational process. In this study, pronounced positive professional socialization occurred

under conditions of high attitude and value consistency among faculty, staff nurses, and head nurses in the clinical agencies. Where there was substantial variance in these attitudes and values, there was little uniformity of socialization. In a similar study, degree of faculty consensus was shown to be a major determinant of the effectiveness of the socialization process (Glicks, 1977). Simpson (1987) identified a sequential process of adult socialization into an occupational role in a study of nursing students in a baccalaureate program.

The changes in nursing students' image of nursing during the generic educational program have been studied extensively (Grisan, Swift, & Gorman, 1974; Gotsch, 1981; Davis & Gorman, 1984, 1979; George, 1980; Glicks, 1977; Glesne & Davis, 1988; Gendrick, 1978; Siegel, 1985; Thomas, 1976; Warner & Jones, 1981). The results of these studies were descriptive rather than experimental, and the researchers did not include in their scope a study of the process of acquiring the cognitive and psychomotor skills characteristic of the professional nurse.

The differences in professional socialization among the three types of professional nursing education programs have been examined in many outcome studies. Among these outcome studies were competency studies (Davis, B., 1972, 1978; Gray, Harnay, & Jaeger, 1977; Karamitis, 1979; McIntire, 1981; Scullione, 1980; Verbeek, Richards, & McCarthy, 1981) and performance studies (Oswell, 1978; Jacobs, 1980; Welch, Hise, & Stanford, 1974; Barrett, 1982). Researchers in most of these studies used ratings by educators or directors of nursing rather than direct investigator observation and the results may have

been biased by the raters' own educational backgrounds. Researchers used the findings of these studies to support the conclusion that nurses from the direct educational programs focused on different problems and that higher education produced more independent nursing action.

The research in professional socialization has been focused on the results of the socialization process rather than on the more general process of learning or on instructional models for facilitating the acquisition of nursing skills and knowledge. Professional socialization has been consistently defined to include the acquisition of knowledge, skills, attitudes, and values. However, the research in this area has been focused almost exclusively on the acquisition of attitudes and values. The acquisition of knowledge and skills (cognitive and psychomotor) has been ignored or assumed. There are not reports that learning theories have been used as a theoretical basis for understanding the learning that occurs in a clinical setting.

Clinical Teaching and Learning in Nursing

Many studies of clinical education in nursing have been focused on clinical teaching. In these studies, investigators have examined clinical teaching with the aim of developing improved faculty evaluation by identifying essential teaching behaviors.

In several studies researchers have reported student opinions about effective clinical teaching which included teacher attitudes, nursing role performance, and teaching actions (Clarke, 1988,

Jackson, 1966; Kame & Schwab, 1983; Layton, 1968; Rames, 1974). Both students and faculty were surveyed in additional studies to allow for data comparison between the groups (Brown, S. T., 1981; Davis & Kerner, 1976; Jaramila, 1979). O'Shea and Parsons (1975) found agreement among faculty and students that faculty availability and feedback were the most important facilitative behaviors for clinical teaching. Faculty assigned a much higher score to role modeling than did students. The authors suggested that the faculty and students defined role model differently and this would account for the different value assigned. In an observational study of instructor interaction techniques in clinical teaching, Long and Flansburg (1980) found that two-thirds of all student-instructor interactions were less than six minutes and consisted of direct questions or information giving.

Fugh (1980) surveyed student and faculty beliefs about the importance of selected clinical teaching behaviors and in the analysis found that students expected their clinical faculty member to first be a teacher, exhibiting behavior directed toward the student as learner, and then to be a nurse, demonstrating how to be a nurse in a real clinical setting. Although faculty and students did not have a high degree of agreement on the relative importance of the items on the list, there was general agreement that the use of feedback in clinical teaching was very important.

The perspective of the teacher has been examined in three studies of clinical teaching. In 1948, Kasser developed a taxonomy of instructional behaviors from observations of clinical teaching. The author concluded that clinical teaching behaviors could be classified into three general groups: a) information gathering about the student

and clinical writing, b) assessment and interpretation in a direct encounter between student and instructor in the clinical area, and c) instrumental behaviors in which the instructor actively intervened in the clinical instructional process.

Infante (1990) studied faculty beliefs on what the clinical laboratory in nursing ought to be. She found that most faculty stated the belief that the student was in the clinical laboratory as learner, not as a responsible care-giver. However, when asked to describe how they would handle specific situations, most faculty indicated that they would not follow this laboratory concept. Infante's study did not involve direct observation of faculty in the clinical area.

In the Fugh (1988) study, the author followed up the survey of student and faculty ratings of relative importance of teaching behaviors with observations to verify student reports of how often these behaviors were used by instructors, to document and describe patterns of behaviors, and to study the individual background of the teaching behavior. Fugh concluded that there was a lack of congruence between nursing faculty belief about importance of teaching behaviors and actual enactment of those behaviors. Fugh discussed reasons for this incongruence in terms of role theory including ignorance of role expectations, inability to perform as a result of inadequate preparation, and absence of motivation to meet the role expectations.

Carr (1983) utilized the concept of symbolic interactionism and ethnomethodology as the framework for studying the nature of clinical teaching from the faculty perspective. The author concluded that the nature of clinical teaching was political, that the teachers' purposes were lived rather than espoused, and that teacher purposes were not

dictated by the clinical objectives of the course. Each teacher in this study had a different (primary operational) frame of reference and interpreted the course objectives via this frame of reference. As a result, the educational environment produced by each teacher was different.

All of these studies of clinical teaching have been exploratory and descriptive in nature, and few researchers have utilized any theory to explain clinical teaching. There did seem to be consensus that there were three categories of desirable behavior for nursing faculty in clinical teaching. Teacher behavior that indicated positive regard for the student was important. Both student and faculty groups agreed on the importance of feedback. There was also agreement between students and faculty that nursing faculty were expected to behave in two roles--that of nurse and that of teacher. In a recent review of literature on clinical teaching, Pugh (1980) stated that "there seems to be no commonly accepted, described, or communicated methodology of effective clinical teaching in any discipline" (p. 62).

Research on learners in nursing education has been focused on common characteristics of students and preceptors (Baker, 1976; Nuttallcamp & Parsons, 1972; Quinn, Van Hooser, Scheffel, & Crowell, 1974; Anderson & Allen, 1974; Butler & French, 1976; Williams, 1970), factors which will predict learner performance (Rutledge, Garfield, & Prether, 1973; Best, Polychronis, & Van Rensdoren, 1975; Tremblay, 1971), and outcomes of specific instructional models such as videotapes, learning modules, programmed instruction, simulation, and computer assisted instruction (Ijzard, Hiebfeldt, & Thompson, 1972).

Birdwhell & Bolzman, 1976; Koch, 1976; Mackie, 1973; Pearson, 1975; Roberts & Thurston, 1984; Schlenkerman, Bolzman, & Farwell, 1984).

Using a grounded theory approach, Wells (1992) examined nursing students' accounts of being learners in nursing. Data from interviews were used to construct the students' view of the nursing world. This study was conducted in Great Britain and the differences in nursing education between Great Britain and the United States were apparent in the report and limits the generalizability of the findings. In none of these studies was the process of student learning examined.

Social Learning Theory

Early efforts in the development of social learning theory (Miller & Dollard, 1941) were based primarily on a behaviorist learning model. Miller and Dollard's position essentially was that the behavior of models often serves as a cue for imitation because imitation has been reinforced through drive reduction in the past. Rotter (1944) developed a closely related theory of social learning linked to need satisfaction. The application of this theory to nursing education as a method of motivating students to high standards of professional practice was proposed by Bruch (1980). The author proposed that nursing students have a high need for instructor approval and that this need can be used to improve student performance if the instructor has positive expectations and gives positive reward. Both of these early social learning theorists attempted to explain imitation within the classic behaviorist framework.

Bandura's Social Learning Theory

In a more recent approach to social learning theory, the behaviorist approach of these earlier social psychologists was combined with a cognitive learning approach (Bandura & Walters, 1949; Bandura, 1969, 1977). According to Bandura, human behavior can be learned either by direct experience or from observation. Direct experience is a more primitive mode of learning and would be much too slow for the complex behaviors that every human must learn. Observational (vicarious) learning is a process in which individuals symbolically store ideas about certain behaviors they have observed. Later they use this coded information to guide their actions in imitating that behavior. Behavior is learned symbolically through central processing of coded information before it is enacted.

Not only can learning occur vicariously (observationally), but it can also be reinforced vicariously. In this way, humans can learn from the success and failure of others as well as from their own experience. Without this vicarious learning, all learning would be by the slow and often dangerous method of trial and error. The process of learning behaviors, such as nursing skills, which involve the life and well-being of another person would be particularly dangerous if allowed to proceed by trial and error. In situations where mistakes are costly in money or human life, there is a heavy dependence on observational learning.

In his social learning theory Bandura emphasized, therefore, that most types of behavior are learned observationally through modeling rather than discovered by direct experience. An observer learns from

a model when the observer codes the model's behavior symbolically (a cognitive process) and then is able to use this coded information at a later time as a guide for behavior. Therefore, according to social learning theory, behavior is learned symbolically through control (cognitive) processing of the elements of the behavior before it is performed.

Attentional Process

Observational learning is accomplished by four component processes. In the attentional process, the first of the four component processes, individuals decide which models they will observe. Observation is always selective. Expecting a person to model itself does not guarantee that she will attend to the relevant behavior or recognize the distinctive features of the behavior. Without this attention and recognition, the observer will not be able to imitate the behavior.

Associational patterns, the people with whom one regularly associates, are an important part of the attentional process because these patterns determine what models are frequently available to the observer. Associational patterns for nursing students may include faculty, peers, health care staff, and students from a variety of disciplines.

The interpersonal attraction of the model is important. A number of researchers have investigated the effect of specific model characteristics on the learning of the observer. Researchers found in these studies that, in general, learning was increased when the

observer perceived the model as being competent, attractive, likeable, and prestigious (Barnes, 1970; Burger, 1971; Freyer & Ray, 1979; Fisher & Harris, 1978; Bandura, 1977).

Bandura and Tucker (1962) found that the greater the perceived competence of the model, the greater was the acquisition of the desired behavior. Kasser (1972) found that nursing students were disillusioned by seeing instructors who were lacking in work experience and thus were only able to model intellectual behaviors. According to Kasser (1980), a major motive in observational learning was the desire of the learner to become like the model. Behavior changes result from learner identification with the model. Kasser (1979) observed that the effectiveness of the modeling process was increased when the characteristics of the model led the learner to perceive the information as having personal relevance. The characteristics of models exerted the greatest influence when the observer was uncertain what the consequences of the modeled behavior was likely to be. The observer judged the probable value of modeled behavior from appearances and signs of achievement in the model (Bandura, 1977).

The attentional process is also affected by the relevance and complexity of the modeled behavior (Bandura, 1977). The relevance of the modeled behavior attracts the observer. Modeled behavior perceived as non-relevant may be selectively disregarded by the observer. Very complex behavior which may attract the attention of the learner may involve more discrete behaviors than can be attended to in one observation. Much of the behavior nursing students observe in the clinical setting is very complex and may draw the attention of the student but involve more than the student can attend to at one

time. The observers' capacities to process information regulate how much they will benefit from observed behaviors. The observer's perceptual set, which is derived from past experience and the current situation, affects what features she extracts from the observation and how she interprets what she sees and hears.

Retentional Process

The second component of observational learning is the retentional process. The human capacity for storing experiences symbolically is essential for observational learning. Observational learning relies mainly upon two representational or coding systems—imaginal and verbal. Some observed behavior is coded in images. As a result of repeated observation, the learner eventually forms enduring, retrievable images of the modeled performances. The verbal representational system, which probably accounts for the speed of observational learning and retention in humans, involves verbal or linguistic coding of modeled events. Most of the cognitive processes that regulate behavior are primarily verbal rather than visual because verbal coding is simpler and faster. Researchers have demonstrated in several studies that observers who coded modeled activities with words, labels, or images learned and retained behavior better than those who merely observed with no effort to code (Bandura & Jeffery, 1977; Bandura, Jeffery, & Jackins, 1976; Gersh, 1971).

As language skills are developed, verbal modeling is gradually substituted for behavioral modeling as the predominant mode of learning. Many social, vocational, and recreational skills are

developed by following written descriptions of how to behave. Verbal modeling is used so extensively because of its speed and convenience, but behavior modeling is still needed for complex psychomotor skills, such as the technical skills of nursing.

Mental and behavioral rehearsal are important retentional processes. The highest level of observational learning is achieved by individuals who organize and rehearse the modeled behavior mentally and then reproduce it in behavior (Jeffery, 1976). When individuals mentally rehearse or actually perform modeled behavior patterns, they are more likely to retain them than if they merely think about them or practice what they have seen. Mental rehearsal in which persons visualize themselves performing the observed behavior increases proficiency and retention (Bandura & Jeffery, 1971).

Motor Reproduction Process

Motor reproduction processes are the third component of observational learning. The learner selects and orders behavioral responses at the cognitive level, initiates the behavior, observes his performance, and then refines his behavior based on that performance (Bandura, 1977). The component skills must be available before an observed skill can be enacted. Learners who possess the component elements can easily integrate them to produce the new patterns; but if some of these skill components are missing, behavioral reproduction will be faulty. When these deficits exist, then the basic subskills required for the complex behavior must first be developed by modeling and practice. In most everyday learning, people usually perform a

close approximation of the new behavior by modeling, then they refine their performance on the basis of feedback from observing their own performance and from observing models of those responses that have been only partially learned (Bandura, 1977).

Motivational Process

The final component of observational learning is the motivational process. Individuals do not assimilate everything they learn from a model. They are more likely to adopt modeled behavior if the consequences of that behavior are something they value. Both observed (vicarious) and experienced consequences will affect future behavior (Bandura, 1977).

Those behaviors that seem to be effective for others are more likely to be adopted than behaviors that are seen to have negative consequences. An individual's evaluation of his own behavior also regulates which observationally learned responses will be performed. People adopt behaviors that they find self-satisfying and reject behaviors that they personally disapprove (Hicks, 1972). Anticipated benefits that are highly valued can increase retention of what has been learned observationally by motivating people to code and rehearse the modeled behavior (Bandura, 1977).

Models are not always aware that they are being modeled. According to Bandura (1977), as learners develop adequate language, much of their observational learning relies on verbal or pictorial symbolic models such as printed material, pictures, television, and other forms of media. Observational learning involves a model, human

or symbolic, who engages in some behavior and a learner who, as a result of observing the model, behaves in a similar, although not necessarily identical way. These learned patterns of response are frequently generalized to other situations that have some degree of similarity to the original learning experience. A major advantage of observational learning is that it provides the learner with a more complete sequence of behaviors for very complex behaviors thereby accelerating the learning process.

Reinforcement is very important in the learning process and is probably most effective when it is vicarious, that is, when the model is perceived as having been rewarded for the behavior. Bandura and Kazar (1964) have shown that self-reinforcement can be taught by modeling. People set certain standards of behavior for themselves and responded to their own actions in self-rewarding or self-punishing ways. This is an important idea for professionals where norms must be internalized.

The idea that "...virtually all learning phenomena resulting from direct experiences can occur on a vicarious basis through observation of other peoples' behavior and its consequences" (Bandura, 1968, p. 438) has significance for educational programs that involve a clinical experience. This is especially important for those educational programs in health care where the life and physical well-being of the client are at risk.

Role Models

The concepts of model and role model appear in the research literature outside the framework of Bandura's social learning theory. Krumer (1980) pointed out the conflict between the nurse role model presented to students in their educational process and the role model discovered after graduation. In a study of role conception changes she showed that an increase in bureaucratic value orientation results from the shift from a school or professionally centered model to a work-centered model. Ruses (1974) found the student expectation that the clinical instructor be a role model, defined as an effective nurse, and that such modeling was perceived by the students to be an essential influence on learning the nursing role. The students rated characteristics of the nurse role higher than characteristics of either the teacher or person role in relative importance in helping them become nurses.

Secher and Stalling (1977) identified four kinds of models in their study of postgraduate professional education. When the student chose specific attributes of a professional that he admired, that individual was a partial model. Persons who modeled attributes that the students did not want to learn were called negative models. Dominant models were individuals whose professional behavior was so exemplary that the student had no expectation of matching his behavior. Stage models were individuals who were one step ahead of the student in the educational process. They modeled the student culture. The students never chose a single model. They modeled specific behaviors rather than people.

In a study unrelated to nursing, Kelly, Saunders, and Marichio (1998) found that students chose models in their performance of a novel task that matched their perception of their ability to perform the task. They suggested that these findings indicated the importance of attempting to ensure success the first time a novel task was performed. After negative feedback, subjects became more resistant to change because their perception of their ability to perform the task decreased.

As part of a grant to develop and improve teaching strategies in a nursing curriculum, Kramer (1993) designed a clinical experience for students where the instructor was first and foremost a role model in patient care. The nursing instructor assumed a primary care giver role rather than the usual instructor role. The instructor was available to the students for advice and help, but it was the students' responsibility to seek her out. Kramer reported that the results were encouraging. Students reported increased learning and enjoyment of the experience, and traditional student outcomes were equivalent to other student groups. This clinical experience was not part of a research design so that these results are evaluative only.

Researchers have reported in the literature that students did use role models in their learning, and role models were perceived to be important. However, there was little to demonstrate how modeling can be used in the context of a nursing curriculum to increase the acquisition of the cognitive skills, knowledge, values, and attitudes of professional nursing.

Summary

The literature on learning in nursing education has been primarily concerned with the learning of the values and attitudes of professional nursing, the characteristics of the learner, and the characteristics of the effective teacher. None of the researchers addressed the process of learning from a student perspective. Bandura's social learning theory has been drawn from the behavioral sciences as a theory that may have some explanatory value for the process of learning in clinical nursing education.

CHAPTER THREE

METHODOLOGY

The Research Perspective

The purpose of this study was to explore and describe nursing students' experience of learning in the context of one clinical practice setting where the students learned to provide care for acutely ill infants. Ethnography is a research methodology developed by cultural anthropologists that is particularly suited for understanding behavior in its social context. The goal of ethnography is "to discover the cultural knowledge people are using to organize their behavior and interpret their experiences" (Spradley, 1990, p. 300). Ethnographic methods have been used increasingly by educators, as well as anthropologists, to study educational settings and problems because of ethnography's focus on contexts and meanings rather than on isolated variables. Wilson (1982) described ethnography as

... a naturalistic, observational, descriptive, contextual, open-ended, and in-depth approach to doing research. Within these bounds, a variety of instruments and data-gathering tools may be employed. The goal of ethnography is to combine the view of an insider with that of an outsider to describe a social setting. The resulting description is expected to be deeper and fuller than that of the ordinary outsider, and broader and less culture-bound than that of the ordinary insider. (p. 952)

The ethnographic world view is one in which the informants are not subjects but are rather experts on what the ethnographer wants to learn about. This world view emphasizes that the natives (people in

the setting of interest) do not realize the full extent of their cultural knowledge and social behavior. There is both explicit, verbalized cultural knowledge and tacit, nonverbalized cultural knowledge. The ethnographer holds that all behavior occurs in contexts and that people change as they change contexts and indeed all contexts are continuously changing. The familiar culture (institution, hospital, race, group) is only one of many cultures within a larger cultural context in which the researcher uses the tactic of "making the familiar strange" (Spradley, 1982).

"Ethnography is the work of describing a culture" (Spradley, 1979, p. 1). Wilson (1981) defined ethnography as an attempt to describe and interpret the nature of social discourse in a selected setting or among a group of people. Both behavior and meaning are described. "The search for patterns and their meanings is the central operation of the ethnographic research process" (Cobbart, 1982, p. 41). The researcher observes the behavior in its natural context and elicits meaning from the people whose behavior is observed.

In doing field work, ethnographers make cultural inferences from three sources: (1) from what people say, (2) from the way people act; and (3) from the artifacts people use. At first each cultural inference is only an hypothesis about what people know. These hypotheses must be tested over and over again until the ethnographer becomes relatively certain that people share a particular system of cultural meanings. (Spradley, 1979, p. 8)

Roberts (1982) listed five characteristics of the anthropological paradigm in which the ethnographic methodology is based: (a) Anthropologists study people in their natural setting, (b) the primary instrument of research is the anthropologist's entire person, (c) it uses the natural history approach which is characterized by "careful

and prioritizing observation, guided by informed questions and followed by generalization based upon the grouping of observed facts and then by a testing of the derived generalization through further observation" (p. 40). (d) cross-cultural? knowledge adds to the interpretation of the data, and (e) the central concept of research in anthropology is culture.

Culture, as used in this study, is defined as "the acquired knowledge that people use to interpret experience and generate social behavior" (Spradley, 1979, p. 8). Culture can be thought of as a kind of cognitive map that participants of a culture refer to in their everyday lives. Yet this cognitive map is not a static, unchanging entity.

Culture is not simply a cognitive map that people acquire, in whole or in part, more or less accurately, and then learn to read. People are not just map-readers; they are map-makers. People are cast out into imperfectly charted, continually shifting seas of everyday life. Mapping them out is a constant process resulting not in an individual cognitive map, but in a whole chart made of rough, improvised, continually revised sketch maps. (O'Neil, 1977, p. 8-7)

Traditional ethnography was macroethnography. It was concerned with a total culture. As anthropologists turned from the study of exotic cultures to the study of cultures and subcultures within their own society, the focus of map ethnographies narrowed. The classroom became the culture to be studied in educational anthropology. Some educational anthropologists have criticized this move from macroethnography to microethnography saying that this narrow focus, while generating important knowledge, does not account for more complex issues that require work of what happens in a particular setting (Lata, 1981).

Belloc (1982) defended the use of microethnography as an appropriate methodology for studying microcultures as long as the researcher retains the realization that any microculture is part of a larger culture and relationships between the two must not be forgotten. Spradley (1980) described microethnography as just a variation in research scope. Microethnography, at one end of the continuum, describes a single social situation. Macroethnography, at the other end of the continuum, describes a complex society. According to Spradley (1980), microethnography, with its focus on everyday behavior in limited educational classroom settings, is a significant development in the ethnography of schooling.

Much of nursing education takes place in the greater social context of a health care agency with multiple actors and events overlapping on the learning process. Ethnography is a methodology suited to describing and interpreting the experience of learning as it takes place in this complex setting.

The Setting

Selection of the Site

The study was conducted in one room of a large pediatric inpatient unit in a large southeastern university teaching hospital. The characteristics of this site that led to its selection included (a) the room selected typically had one to seven patients and, during most clinical practice days, two students were assigned to patients in this room for clinical practice, (b) there were two instructors in the same clinical course who had students for clinical practice time

as this unit each week thereby doubling the opportunity for observation time, (c) the patients were infants and presented several repetitive types of nursing care needs, so many students had the opportunity to learn similar nursing skills, (d) the staff nurses on this unit were known to the researcher, and they were willing for her to be present as a participant observer in this setting, (e) the two College of Nursing instructors were willing to have this researcher-observer in the clinical area as they worked with students, and (f) pediatric nursing was the researcher's clinical specialty.

Getting Access to the Site

Once the site was selected, the researcher submitted a written description of the proposed project to the director of nursing services in charge of educational activities in the hospital. This person granted approval for the researcher to collect data at this site. The researcher met with the nursing supervisor of the selected unit and explained the general purposes of the project. In addition to explaining data collection methods, the researcher described her own role as passive participant observer. The researcher described her role as sitting in the room, writing field notes, and not interacting with students or patients unless a patient was endangered by a student's behavior. The nursing supervisor and the researcher also discussed a possible alternative site for data collection in the same clinical unit in the event that the room selected as the primary site was closed due to low patient census. An adjoining room that was

essentially identical in physical layout and types of patients was identified as an alternative site.

There were two instructors who taught the course that included the pediatric clinical experience that took place in this setting. These instructors were approached individually, the project purposes and methods were outlined, and permission was obtained to observe during their clinical practice times. Both instructors were interested in the questions posed by the study. One instructor was particularly enthusiastic about this project and remained so far the six months of data collection. She frequently reminded the researcher of her interest in the findings of the study. Arrangements were made with each instructor to meet with each new group of students (there were a total of twelve groups over six months) during the clinical orientation conference in order to explain the purposes of the research to the students and to obtain student consent for the observation.

During this orientation conference the researcher explained that she was interested in the students' experience of learning in a clinical setting. The students had all had an undergraduate course in nursing research which focused primarily on quantitative methodologies. They were very interested in the idea of qualitative research and asked many questions. In addition to describing the methodology, the researcher assured the students that the researcher did not have an evaluative role and that no information about what was observed would be communicated to their instructor. The researcher informed the students that their identity would be protected in the final report and that they would have access to the findings of the

study. There were no students who refused to participate in the study. Two students did not keep appointments for interviews, but this appeared to be a scheduling problem rather than an effort to avoid the interviews. The researcher explained her role as posing participant observer including the possibility that she would intervene in an emergency. This orientation was repeated for each of the twelve groups of students.

The Clinical Course

The students who were the subjects of this study were seniors in a generic baccalaureate nursing program at a state university. The clinical course (Nursing Process Three) that these students were enrolled in during the study period was one of three clinical courses required during the senior year of a five semester upper division clinical major. Nursing Process Three and Nursing Process Four were offered twice each year. The entering senior class was divided into two groups. One group took Nursing Process Three during the first semester of the senior year; the second group took Nursing Process Four. During the second semester of the senior year each group took the alternate course. This arrangement was necessary because of the demand for clinical facilities and for best utilization of faculty within a variety of clinical specialties.

The approximately 20 students who were enrolled in Nursing Process Three during each semester were further divided into four groups. Each of these groups was assigned to one of the four adult medical-surgical nursing faculty. Each of these small groups was

further divided into three groups for purposes of determining when during the semester they would be assigned to one of the two pediatric nursing faculty (See TABLE 1). At any one time each of the six clinical faculty were responsible for 30 to 32 students. During the semester each of the students spent 8 to 10 weeks on their assigned adult clinical unit and 4 to 5 weeks on the pediatric clinical unit.

TABLE 1. CLINICAL ROTATION SCHEDULE

Clinical Unit	First Five Weeks	Second Five Weeks	Third Five Weeks
Adult 1	Groups 1A and 1B	Groups 2B and 1C	Groups 3A and 1C
Adult 2	Groups 2A and 2B	Groups 2B and 2C	Groups 2A and 2C
Adult 3	Groups 3A and 3B	Groups 3B and 3C	Groups 3A and 3C
Adult 4	Groups 4A and 4B	Groups 4B and 4C	Groups 4A and 4C
Pediatric 1	Groups 1C and 2C	Groups 1A and 3A	Groups 1B and 2B
Pediatric 2	Groups 3C and 4C	Groups 3A and 4A	Groups 3B and 4B

The focus of this clinical course was learning to provide nursing care for a variety of patients with acute and chronic health problems that require hospitalization. More detailed information on this course is included in Appendix A. Because the pediatric units at the

university teaching hospital) were the only inpatient pediatric facilities in the city, all students in this course had their experience in acute pediatric nursing at the same facility. The remainder of their clinical experience was on one of four different adult units—two at this same hospital and two at the affiliated Veterans' Administration Hospital. Because each of these four units had a different kind of patient, the students came to the pediatric experience with widely varying kinds of experiences. Some students had had primarily experience with medical patients and others primarily with surgical patients. The goal of the College of Nursing faculty was for all students to have comparable experiences, but students reported that their clinical experiences were often very different from their classmates.

Course evaluation was based on clinical performance (80%), a clinical project (20%), and a case study (20%). The student had a formal evaluation conference three times during the course. The two instructors collaborated in the preparation of the final evaluation (See Appendix B).

The Pediatric Clinical Practice Experience

The pediatric clinical experience took place on two clinical units at a large teaching hospital. The first unit was a 41-bed unit for infants, toddlers, and preschool-age children. The second unit was a 38-bed unit for school-age children and adolescents. This study was conducted in that portion of the first unit that was designated for infants. During the four or five week pediatric

clinical practice experience the students usually, but not invariably, spent two to three weeks on each unit. Each student was expected to have clinical experiences with children in a variety of age groups. Consequently, a student would usually have only a two day experience in the room where this study was conducted. Therefore, observations of any one student were limited to that two day period that they spent in the infant section of the pediatric clinical unit.

The students were in the clinical setting for 36 hours each week. Because two groups of students were having pediatric clinical experience during any given week, there were students present on the unit for 36 hours each week. The students' preparation time, both on and off the clinical unit but not in direct contact with patient, was in addition to these 36 hours. During the spring semester the weekly clinical experience consisted of one full eight-hour shift on days (3-5), one four-hour evening shift (3-7), and one-four hour morning shift (7-11) for each group. During the summer semester one group's weekly scheduled clinical experience time consisted of two full day shifts (7-15). The other group was scheduled for two full evening shifts (3-11) each week. Concurrent with the clinical experience, the students had two hours of clinical conference time and six (eight in the shorter summer term) hours of lecture each week. The lecture content was rarely synchronized with the clinical experience because of the need to rotate students to various clinical settings. Consequently, the student who was caring for an infant with meningitis might be studying myocardial infarction in the classroom. This meant that the clinical experience with a particular kind of patient might precede the lecture content on that particular problem. This had the

effect of increasing the amount of time the student needed to spend in preparation for the clinical experience.

The instructors attempted to assign each student to a one week experience in this setting with infants. However, assignments were always dependent on the availability of patients. This pediatric unit had a high occupancy rate but, one week during each semester of the study period, the room used for this study was closed because of low patient census. During one of these two week periods the room designated as an alternate site was used for observations. During the second week no observations were conducted as there were no students assigned to the alternate room.

Physical Setting

Because this hospital was a referral center, the infant patients either were acutely ill with complex medical or surgical problems or had chronic complex problems requiring ongoing hospitalization. Typically there were many pieces of medical equipment, such as oxygen setups, heart rate and apnea monitors, suction machines, and infusion pumps. When there were six or seven patients in the room it was a really crowded setting. In addition to the nursing staff, there was a steady stream of residents, interns, attending physicians, occupational therapists, physical therapists, clinical dieticians, pharmacists, clinical pharmacists, physicians' assistants, radiology technicians, respiratory therapists, students from most of these disciplines, nurses, housekeeping personnel, ward clerks, parents, and grandparents. Somewhere in this crowd, the nursing students tried

to make sense of what was going on, provided care for their patients, and learned about pediatric nursing. The following excerpt from an early field note described the setting:

Leaving the room counter-clockwise from the door: infant in crib. Crib has a top that is raised. Infant is on a cotulla board, fastened on with a harness. The second infant is in a crib, has a tracheostomy, continuous tube feeding with BID infusion pump, cardiac monitor, and oxygen running to the tracheostomy head. She has navy boys in the crib. The third patient is in an infant radiant warmer with his head elevated. He has a gastrostomy tube which is connected to a syringe which is taped to the overhead heater panel. The fourth patient is a toddler-sized child who appears to be severely brain damaged. The crib has a sliding top. There are gloves and suction equipment in the crib. There is one nodule in the bed. The fifth patient is in an infant radiant warmer, under an overhead with oxygen running. Has a red isolation bag attached to the warmer. Child has a lateral thoracotomy scar on chest. Sixth patient has a crib with navy boys, has nasal oxygen, BID infusion pump for anti-jugular feeding, and a cardiac monitor. He is now in the infant swing. After sixth crib are trash containers, the linen hamper, the infant scale, sink, cabinets, and a small refrigerator.

During a typical day in the critical care the students would arrive at least 15 minutes before the beginning of the shift. They would check the patient roster to verify that their patients were still on the unit. Almost every week at least one student had to choose another patient unexpectedly because her assigned patient had been transferred to another unit or have been discharged. This was very upsetting and frustrating to the students. In response to a researcher question about her initial reaction to the unit, one student said:

My first reaction to [unit] was utter terror because my patient had been moved to [the pediatric intensive care unit] and I had to find somebody new. The first day is kind of hard. You have to get oriented, find out where things were and spend time running back and forth

searching for things. . . . it was a little too busy to really sleep and find out where things were.

This student had to cope with the usual difficulties of the first day in a new area and, in addition, she had not had an opportunity to prepare to care for this new patient. She also felt that the preparation time for the patient who was transferred was wasted.

After verifying that their patients were still available, the students tried to locate the nurses who were waiting for change of shift report. On this unit the nurses did not meet together in a large group for change of shift report. Each nurse that was leaving reported to her counterpart who was arriving. They might do this at the patient's bedside, at the nursing station, or in the chart room. This system was very confusing for the students, and they frequently missed the actual report and had to locate the nurse that was assigned to their patients and ask for another report. After hearing the report, the pattern was extremely variable and depended on the condition and needs of the students' assigned patients. The students normally spent a lot of time just locating the equipment and supplies they needed and asking questions to ascertain the nursing care routine. The appearance of the instructor was unpredictable. The students usually, but not invariably, saw the instructor two times each shift. The length of time the instructor spent with each student also did not appear to follow a predictable pattern. The staff nurses were very helpful in answering students' questions, supervising them, and helping them when the instructor was not in the area. During the eight-hour shift the students usually had one short coffeebreak time and a break for a meal. Before the end of the shift, the students

were expected to have completed all of the nursing care, completed the charting, and verbally reported to the staff nurse assigned to their patients. It was not uncommon to find students still on the unit doing their charting after the end of the shift.

Research Methods and Procedures

The Research Model

The research model is cyclic rather than linear in nature in contrast to the typical quantitative research model in which the researcher states hypotheses, collects data to test the hypotheses, analyzes the data, and draws conclusions. In doing ethnography, the researcher enters a cyclic process of asking questions, collecting data, and analyzing data again and again. Spradley (1982) has identified the steps in this process as the Developmental Research Sequence which consists of asking ethnographic questions, making an ethnographic record, and analyzing ethnographic data. The procedures of the Developmental Research Sequence were adapted for the collection and analysis of ethnographic data for this study.

In the process of data analysis more questions emerge and observations become more focused so that data analysis is an integral part of the research process rather than the end point. Ryan (1983) pointed out that for many ethnographers, the essence of ethnography is this dialectical or interactive model in which initial questions may change during the course of the investigation.

Asking Ethnographic Questions

One of the characteristics of ethnographic research is that it begins without precise hypotheses or instruments. However, "one begins field work not with a tabula rasa but with a foreshadowed problem in mind" (Gllicks, 1982, p. 498). The problem was general in scope because the researcher was attempting to understand a setting in its own terms and could not predict in advance precisely what would be significant or where the data collection should be focused. This discovery of new questions and hypotheses was an essential part of the research process (Gllicks, 1982).

At this point in the research process, it is overly necessary to realize that a suspension of judgment is required during the data-gathering and early analytical phases of all ethnographic research. This does not mean that a researcher begins the hunt for patterns with a blank mind, nor that beginning pattern analysis jumps full-blown from a mental vacuum. It does mean that any assumptions, hunches, intuitions, or conclusions with which the research was begun, or that arise in the early stages, are considered questions, not answers and that data are sought for their disconfirmation as well as their confirmation. (Robbert, 1982, p. 41)

In this study one broad general question was posed to serve as a general framework for the researcher: "What kinds of experiences and behavior are part of the process of learning clinical nursing skills in a clinical setting with acutely ill infants?" In order to provide some structure for the initial observations and interviews, the following list of questions was posed. These questions were modified as part of the ongoing process of data analysis:

1. What sources of information do students draw on to learn clinical nursing?
2. How do students structure their learning?

3. What factors in the clinical setting affect student learning?
4. In what ways is the process of learning the same for all students?
5. What are the differences, if any, in learning goals between the students and instructors?
6. What kinds of learning occur in the clinical setting?
7. What are the underlying rules which govern learning behavior in the clinical area?
8. What functions do the students' clinical behavior serve?
9. What are the contexts in which learning occurs?

During the course of the research different types of questions were asked. These questions included descriptive questions, structural questions, and contrast questions. Each kind of question focused the observations and interviews in a different way and were associated with different levels of data analysis.

Descriptive questions were asked during the early observations when the researcher was developing a broad description of the social scene. These questions included "Who are the people in this room?" "What kinds of things do nursing students do here?" and "How does the student get started?"

After the initial categories were identified in early data analysis, the researcher went back to the setting and the informants to add depth to the identified categories. An early observation was that students asked many questions. The researcher posed two structural questions. "What are all the kinds of questions students ask?" and "Who are all the people to whom students' questions are

directed?" These and many other structural questions were asked during both observations and interviews. This type of questioning enabled the researcher to narrow the scope of the research and to fit it in all the elements in the categories of interest.

The final type of question was the contrast question. Contrast questions were used to identify the differences between elements of a category. For instance, in the category *Kinds of Student Goals* were the looking good as a student goal and the looking good as a nurse goal. The researcher asked the contrast question, "How are these kinds of goals different?" This question led the researcher to search field notes and interview transcripts and to conduct additional observations and interviews searching for the differences between these two kinds of goals.

Asking questions and making observations appropriate to the questions is the basic cycle of ethnographic inquiry (Spradley, 1980). The questions determined the nature of the observations, the answers to each set of questions determined the next set of questions throughout the data collection process.

Collecting Ethnographic Data

Ethnography is not a single technique although it is often identified with participant observation. Ethnographers use a variety of techniques to discover the answers to the questions that arise. And as the evolving nature of the research process allows for modifying the research questions as the study proceeds, modification of data collection techniques remains a possibility. Wilson (1992)

cited the tremendous variety of methods for collecting data, emphasizing that traditional ethnographers have used a variety of methods in a single setting to increase the validity and reliability of their findings. In addition, the unique character of each setting requires an individualized set of techniques. Pelto and Pelto (1978) have noted approvingly a trend in anthropology toward increasing quantification and emphasized the need for multi-method, multi-instrument approaches to anthropological research.

In this study the researcher used students' verbal messages about learning, their clinical practice related behavior, and their use of learning resources as indicators of their experience of learning in a clinical practice setting. The major data collection tools used in this study were participant observation and interviewing. In keeping with the ethnographic model, the researcher served as the primary data collection instrument.

Participant observation

Participant observation is a technique for gathering data about a situation while immersed in that situation. The participation may range along a continuum from passive participation, where the observer is merely present in the setting but does not actively engage in the activity taking place, to the other end of the continuum where the researcher is a total participant. The researcher in this study was a passive participant. Her purpose was known to the instructors, staff, and students. The researcher did not participate in the instructional or nursing care activities in the setting except in situations where a

patient was endangered by failure to intervene. During the study period there were only two situations in which the researcher intervened. In both of these situations a person left a side rail to a crib down and when she walked away from the crib, the researcher pulled up the side rail. The first incident occurred very early in data collection and involved a nursing student whose instructor was present in the room but working with another student. The second incident involved a physician. There were many situations that were much more ambiguous, and it was difficult for the researcher to remain seated and silent. One of the questions posed by the study related to how the students solved problems, so it was necessary to allow the students to struggle with the problem without any assistance from the researcher. The status of being in a situation where the researcher had the specialized skills required to function in that setting and yet did not participate was a problem that required ongoing evaluation and decision making.

Observations were done at various times in the clinical day for periods of one to two hours. A total of 76 hours of observations were made during the course of data collection. Upon arriving on the unit the researcher would greet the staff nurse and nursing assistants in the room and, if needed, explain her purpose. The nursing staff was quite large, so maintaining access was an ongoing task. Occasionally one of the nurses would stop the researcher to ask about the progress of the research task, for the most part, they ignored the researcher. The first few weeks several staff nurses appeared to be very conscious of the researcher's presence and would ask questions or make comments. This stopped entirely after about a month of observations. During an

early observation period one nurse who had been very curious about what the researcher was doing had just discussed a diagnostic procedure a patient was going to have with the patient's nursing student. The nurse walked over to the researcher, leaned over her shoulder at the field notes and said, "Oh I talk loud enough. I wouldn't want to be diagnosed."

The researcher's observations were recorded at the time of observation in the form of handwritten fieldnotes. Note-taking was done in full view of the individuals being observed. The researcher selected a chair in the room where she had full view of the students' activity in the room. The spot selected was out of the traffic pattern and only occasionally needed to be changed during the course of an observation. It was not uncommon for several people to be seated in this room holding an infant or working on charts so the researcher's presence did not appear unusual.

Although there was no observable reaction to the researcher's presence, it is one of the limitations of observational research that the observer's presence changes the cultural scene in some way. The natural constraints of the social setting and repeated observations tend to minimize this effect.

The presence in the observational situation of the very social constraints the sociologist ordinarily studies makes it difficult for the people he observes to teller their behavior to what they think he might want or expect. However much they want to, the real consequences of deviating from what they might otherwise have done are great enough--loss of a promotion or of reputation in the eyes of public members of their community--that they cannot. (Hochs, 1970, p. 47)

In an effort to determine the extent of the observer effect the researcher asked each student at the end of the interview, "What was

is like for you to have me there watching you?" and "Do you think you did anything differently because I was there?" Most students acknowledged that they were very aware of the researcher's presence and that they were conscious of what they were doing. However they all said that they didn't do anything differently.

Student: I forgot about you very quickly. I was so busy to make the first night. I don't even remember when you left.

Student: I thought it would [affect] me when you told us, but it really didn't.

Student: I did think later how stupid I must have looked.

Student: I felt like I was being watched.

Although early observations were directed toward a general description of the setting, the majority of the observations were focused on the students' activities. The students' verbal and non-verbal behavior were the primary focus. The patients, instructors, and staff nurses were included in the observations when they were included in the students' activities.

The researcher observed 75 hours of nursing student activity in this clinical setting over a six month period in the spring and summer of 1984. Observations were distributed throughout the days and hours of the scheduled clinical experiences.

The anthropologic interview

This research technique was used in conjunction with the participant observation to ascertain meanings and cognitive processes that could not be observed. The researcher also verified hypotheses

about the data by checking them with students in the study population. Beginning with the fifth week of observation, each student was interviewed as soon as possible after the period of observation. The researcher used a frequently revised list of questions as a partial guide. These questions were based on what the researcher had observed as well as questions that evolved out of ongoing data analysis. For example, the question, "What was your initial reaction to this clinical unit?" was used as an initial question to get the students started talking. The conversational nature of these interviews often led to unexpected information which prompted additional questions. In the interviews contained identical sets of questions. Near the end of the data collection period, questions intended to test researcher hypotheses about the data were used in the interviews.

The researcher interviewed 30 students during the six-month data collection period. The interviews were conducted in an office in the College of Nursing away from the clinical setting. In order to capture interview data while concentrating on the flow of the interview, the researcher received permission from each student to tape-record the interview.

Taking an Ethnographic Record

The major portion of the data was recorded in the form of field notes, transcribed interviews, and a research journal. The researcher took field notes during all observations. This notetaking was done at the actual time the activity was occurring. The researcher wrote notes openly and attempted to record the students'

activities and conversations in as much detail as possible. This account written at the scene was what Spradley (1982) called a condensed account. In a condensed account, the researcher recorded words, phrases, and observations which helped her to recall activities and conversations in more detail later. Immediately after the observation period, the researcher would fill in these details creating what Spradley called an expanded account. Any intervening activity between the observation and filling in the notes would decrease the amount of detail that the researcher could recall. The notes were written in concrete descriptive terms and recorded verbatim language whenever possible. Some subjective comments and questions for later interviews were included in the field notes. These comments were set off by brackets to separate them from the record of clinical activity. The handwritten, expanded fieldnotes were finally typed into a formal protocol that served as a major form of data for analysis. The student interviews were all tape recorded. The interview tapes were then transcribed into typed protocols and the tapes were erased to ensure student confidentiality.

In addition to the typed field notes and the transcribed interviews, the researcher kept a research journal. Spradley (1973) described the research journal as "a record of experiences, ideas, fears, mistakes, confusions, breakthroughs, and problems that arise during field work" (p. 110). This journal contained the record of the researcher's steps in the process of arranging access, reactions of instructors, students, and staff nurses throughout the course of the study, and the ethical dilemmas posed by the researcher's presence in the clinical setting. The researcher also recorded any ideas and

thoughts about the data as they occurred. These were what Spradley (1979) called analysis and interpretation notes.

Analysis and interpretation notes often represent a kind of brainstorming. Ideas may come from past reading, from some particular theoretical perspective, from some comment made by an informant. It is important to think of these field notes as a place to "think on paper" about the culture under consideration. (Spradley, 1979, p. 76)

The research journal also served as an important record of researcher attitudes and biases that were examined for their effect on the data analysis.

The typed field notes, transcribed interviews, and the research journal were the written records of data collected in this study. Throughout the study period they provided the substance for the ongoing data analysis.

The researcher is the primary instrument of data collection in ethnographic research. Because of this, results of ethnographic research are frequently criticized on the basis of researcher bias. In order to minimize researcher bias or error in data collection and analysis, the following strategies were employed: (a) by using both participant observation and interviewing, explanations of behavior derived from data collected by one technique were checked with data from the second technique. The concept of validating the researcher's explanations by data from more than one source is referred to as triangulation; (b) as hypotheses emerged from the data, the researcher returned to the setting to search for negative evidence (LeCompte & Goetz, 1992). This testing of hypotheses against the daily reality of the social setting is an important factor in validation; (c) these same hypotheses were also shared with participants from the setting to

order to elicit feedback that aided in confirming, revising, or rejecting the researcher's emerging hypotheses; and (4) the Journal entries were searched for evidence of researcher bias.

Threats to validity were reduced by several factors inherent in an ethnographic research methodology. The long period of data collection provided time and opportunity for on-site data analysis and construct testing. Interviewing was necessarily less directed than most instruments used in other research designs and therefore was closer to participant reality. The natural settings in which participant observation takes place are more likely to reflect the reality of the native's life than what would be observed in a contrived setting. Finally, ethnographers incorporate a process of introspection and constant reevaluation into the data analysis to uncover possible researcher biases (DuCompte & Goetz, 1992).

The rich detailed data produced by field work have an important use. They counter the safe dangers of respondent deficiency and observer bias by making it difficult for respondents to produce data that uniformly support a mistaken conclusion, just as they make it difficult for the observer to restrict his observations so that he sees only what supports his prejudices and expectations. (Becker, 1970, p. 92)

Analyzing Ethnographic Data

The data from both participant observation and ethnographic interviews were in the form of protocols typed from field notes or audiotapes. These data were analyzed throughout the course of data collection using the four-step method proposed by Spradley (1979, 1980).

1. *Semantic analysis*: This first step of data analysis, which began as soon as the first observation was completed, was a search for categories of meaning, what Spradley called *cultural domains*. These categories were discovered by reading the protocols and asking how the objects, behaviors, and events could fit into categories. Spradley listed nine semantic relationships that could be used to question the data and discover these categories of meaning. The most helpful semantic relationships were *subset inclusion* (X is a kind of Y), *sequence* (X is a stage in Y), *rationality* (X is a reason to do Y), *attribution* (X is a characteristic of Y), and *means-end* (X is a way to do Y). Semantic analysis continued throughout the study.

2. *Taxonomy Analysis*. In this second phase of data analysis, the researcher attempted to discover how domains were connected or organized. A *taxonomy* reveals subsets and the way individual domains are related to the whole. Cultural meaning comes, in part, from the way the things, behaviors, and events in the cultural scene are organized and the taxonomy is a way of visualizing this organization. One taxonomy, *Kind of Student Goals*, became the framework for the findings of the study.

3. *Componential Analysis*: This third phase of data analysis was a search for attributes or characteristics associated with cultural categories. It was a search for the units of meaning people assign to cultural domains.

4. *Theme Analysis*. Spradley (1986) defined a cultural theme as "any principle recurrent in a number of domains, tacit or explicit, and serving as a relationship among subsystems of cultural meaning" (p. 241). Although it is unlikely to find a theme that

within all cultural domains, a theme should have a high degree of generality and occur in several domains. The theme analysis served to make sense of the whole.

Through the period of data analysis there was a constant interaction between data collection and analysis with questions emerging from the data to guide the researcher's observations and interviews. This cyclic process is the fundamental principle of ethnographic research.

The researcher's findings are presented and discussed in the next two chapters. In Chapter Four the nursing student perspective is defined and discussed. In Chapter Five the process of learning a clinical skill is described, and the effect of the nursing student perspective on this process is discussed.

CHAPTER FOUR

THE NURSING STUDENT PERSPECTIVE

The purpose of this study was to explore and describe the nursing student's experience of learning within the context of one clinical practice setting where the students learned to provide nursing care for acutely ill infants. The researcher focused on student actions in the clinical setting, especially student-instructor and student-staff interactions, as well as students' verbal reports of the experience in an interview setting outside of the clinical area. More specifically, observations and interviews were focused on students' verbal messages about learning, their clinical practice related behavior, and their use of learning resources. These kinds of data were used as indicators of the students' experience of learning in a clinical setting.

During initial analysis, data from field notes and interview transcripts were categorized into domains based on semantic relationships. In the process of data analysis more than 100 domains were identified. Although many of these domains were not significant to the findings of this study, it was not possible during early data analysis to determine which domains would be important. As the completion of the data analysis, a relatively small number of domains were especially helpful in constructing the taxonomies which led to an understanding of the data. These domains included Areas of Student-Instructor Interactions, Reasons for Student-Instructor

Interactions, Characteristics of New Skill Acquisition, Kinds of Student Problems, Kinds of Things that Hinder Learning, Kinds of Things That Help Learning, Ways Students Learn New Skills, Ways to Improve Chances of Looking Good to the Instructor, Ways to Teach, and Ways to Get Help. Developing taxonomies was an analytic method that looked across domains to create new domains. Taxonomies were used to provide a larger picture, showing how several domains were related. Kinds of Student Goals was an important taxonomy that emerged from the taxonomic analysis of several smaller domains. Theme analysis, a search for an organizing, unifying theme for the data, produced the idea of a nursing student perspective.

The basic concept of perspective was derived from research in symbolic interaction (Becker, Geer, & Hughes, 1968; Becker, Geer, Hughes, & Strauss, 1961) and served as a theme for the findings of this study. According to social interaction theory, individuals create meanings for people, things, and events through their interaction with those people, things, and events. The concepts of symbolic interaction were found to be useful in understanding and delineating a system of student beliefs about the clinical practice experience that guided student behavior in the clinical practice course. As the nursing student perspective is described, data from the taxonomies will be used to illustrate and support each aspect of the perspective. The excerpts from field notes and interview transcripts used as illustrations were selected from many examples as being representative of the notions, statements, and shared beliefs of this group of nursing students.

The nursing student perspective that emerged from the data was based on evidence from all students in the study group. A search for negative evidence was used to eliminate those aspects of the perspective that were not shared by the group as a whole. All aspects of the perspective were shared by the group in varying degrees. However, the individual students were not equally affected by each aspect of the perspective.

Student Perspective of the Learning Environment

The concept of perspective has been used as an analytic tool for understanding and organizing the ways in which groups of people act in a given environment or situation (Flecker, Gear, & Hughes, 1988).

Perspective has been defined as

... a coordinated set of ideas and actions a person uses in dealing with some problematic situation, ... a person's ordinary way of thinking and feeling about and acting in such a situation. These thoughts and actions are coordinated in the sense that the actions flow reasonably, from the actor's perspective, from the ideas contained in the perspective. Briefly, the ideas can be seen by an observer to be one of the possible sets of ideas which might form the underlying rationale for the person's actions and are seen by the actor as providing a justification for acting as he does. (Flecker, Gear, Hughes, & Strauss, 1981, p. 38)

This concept of perspective allowed the joining of data that described the students' behavior to data that consisted of student statements that reflected the beliefs which are associated with the observed behaviors.

The perspective nursing students developed as they interacted with the environment in which clinical education took place served as a guide to their actions within, and in relationship to, that

environment. Included in this perspective were student goals, the types of actions that were consistent with these goals, the criteria for goal achievement, and student perceptions of student, instructor, and staff nurse roles. This perspective, then, was a shared understanding of what the world of clinical nursing education was like for the student, what was expected behavior, what was permitted behavior, why they were in the situation, and what they should get out of the situation. This perspective became the framework out of which the students acted, so it was within this framework that the student learning process was examined. There was a larger perspective, of which this is a part, which guided the students' overall actions as college students and nursing students outside the clinical practice setting. This study was focused only on that portion of the perspective that was explanatory for behavior in the clinical setting.

This chapter will be a description of the nursing student perspective that guided student actions in the clinical practice course. This perspective included six goals with actions directed toward goal achievement and criteria for goal achievement, and the perceived roles of nursing student, instructor, and staff nurse. The process through which the nursing student learned clinical skills and the effect the nursing student perspective had on this learning process will be described in Chapter Five.

Student Goals

Regardless of the faculty intentions in placing students in a clinical setting, the students soon developed their own sense of purpose for this clinical experience. These goals were not unique to this brief clinical experience with sick infants, but had developed over time beginning with the goals and expectations the students brought to the first clinical course in the junior year and becoming more refined with each clinical experience. By the time these students arrived at the pediatric clinical assignment sometime during their senior year, they had been placed in 9 to 12 other clinical settings for lengths of time varying from a few hours to 30 weeks. Frequent student references to events in previous clinical experiences during the interviews pointed to the evolving nature of this perspective. Students described their experience of this clinical assignment in relationship to previous clinical experiences. They compared clinical settings. They talked about how this current instructor was like or not like previous clinical instructors. The students implied that their behavior in this clinical course had been shaped by experiences in their previous clinical assignments.

There were six major goals for the clinical practice assignment as perceived by the student: (a) to cause no harm to a patient, (b) to help patients, (c) to integrate theory-based knowledge from lecture and reading into clinical practice, (d) to learn various clinical practice skills, (e) to look good as a student, and (f) to look good as a nurse. These six goals formed the framework for the perspective that guided student behavior in this clinical practice course.

First To Be Done

The most obvious fact about the clinical practice setting for the students was that they were expected to learn by caring for real people. This was both exciting and anxiety provoking for the nursing students. A consistently recurring theme in the interview data was the students' concern about the possibility of harming a patient through their lack of knowledge or skill. The goal of doing no harm emerged as the goal with the highest priority in determining student actions. Actions directed toward the other goals were always evaluated in light of this goal. Potential actions that might cause harm to the patient were rejected, and alternative actions that protected the patient were selected. The students developed strategies for achieving the other goals that were consistent with this first goal.

In the pediatric clinical assignment, the students were not only expected to acquire the new knowledge and nursing skills unique to pediatrics, but also had to adjust to working with infants who were often tiny and fragile-looking. Most of the students in this primarily young-adult group had never handled normal infants, much less those acutely ill, frightening infants. The students' general awareness around infants increased their perception that they easily could do something wrong that might harm a patient. These two students were interviewed after two 8-hour experiences in the study setting.

Student: When I started nursing school I had hardly ever picked up a baby in my life and I thought they'd break. You're always afraid you're going to drop them.

Student: I had one day in NICU is (they-down neonatal intensive care unit) last year as my experience with

1986) was very limited and I was a little scared of handling them--of being able to handle them without hurting them.

In a conventional educational environment the assignments that students receive and attempt to complete have been planned by the course faculty. The students can anticipate the kinds of actions they will need to perform to carry out their assignments. The assignments nursing students received in the clinical practice course were usually to provide complete nursing care to actual patients whose nursing care needs were not always predictable by either instructors or students. The students could suddenly find themselves in situations where they were frightened by a patient's signs, symptoms, or reactions. The student did not always know if he should be concerned or what he should do. Even when the student knew what needed to be done, he did not always know how to perform the needed skill. The students spent a lot of time getting help simply because they were not sure if what they were seeing was a serious threat to the patient's well-being.

Interviewer: Yesterday when you first started working with [TRIC], you bulb-syringed [suctioned] her and then you went out of the room and came back with the [staff] nurse. I wonder if you could tell me what you were thinking during that episode?

Student: Well, I didn't think bulb syringing was attractive enough. She was still sounding really rattly and there was [mucus] coming out of her track [tracheostomy tube] and I had not suctioned a track before--only in the [skills] lab as a dummy and not even with the machine turned on. So I didn't like to do it myself and is that's why I got the nurse. I felt kind of panicky when the bulb suctioning didn't work and there was no nurse there to help me.

This infant needed to be suctioned but was not in serious respiratory distress. This was a frequently occurring condition for her. The student had not yet discovered that this infant responded to any kind

of stimulation with the loud respiratory sounds typical of an infant with a tracheostomy. It was not an emergency situation, but the student's behavior reflected her fear that the patient would be harmed because she did not have adequate skills to do what she thought needed to be done.

Because this clinical experience was so brief, students were even more aware that their knowledge and skills were limited. Even the skills they had already developed with adult patients were not necessarily to be trusted here. The students knew that working with children required different assessment and intervention skills.

Student: For me the scariest thing is that I haven't been around patients long enough to know which ones are really sick and which ones aren't, and what signs when they breathe are okay and which ones mean that I need to get some help, and for which age to which heart rate appropriate, and it's so much and it's so new.

In this clinical assignment students were expected to choose their patients (or get the patient assignments their instructor had made) the day before the scheduled clinical time and to do reading on the disease processes, anticipated nursing care, and medications in preparation for doing the nursing care. The fear of harming a patient was a major motivating factor for this student preparation before the clinical experience. A student might try to anticipate the emergencies that could occur based on his interpretation of the infant's disease and physical condition. These anticipated problems would then guide his preparation.

Student: One thing that motivates me is "what if? What if DNR happened to your patient? Are you competent? Do you really know what you're doing? Are you going to be able to handle it without freaking out."

Another student told the researcher that there was so much work to do in the two theories she was taking that she sometimes had to make choices about what she could study. Because the patient was involved and his well-being and safety would be affected by what the student did or did not do during the clinical practice time, the student usually assigned higher priority to preparing for the clinical practice experience.

Student: When it comes to clinical, you don't have any choice but to be prepared, so if you have a choice between a clinical and a test, the clinical has priority.

The goal of doing so here provided the students with a sense of urgency and necessity about their learning that was not present for learning in the classroom courses.

Student: I've learned more of nursing not just in clinical but in preparing for clinical than I do in lecture classes. It's the same stuff but when you're dealing with somebody's life—it means something to you and you really get in there and learn it.

The students experienced a tension between their own need to learn and their sense of justice for the patients. In interviews, they frequently expressed the need for more knowledge of skills before coming to the clinical area.

Student: It's not really fair to the patient to a certain extent to always have you be practicing on them without more background.

Student: [The instructors] sometimes scare us with the way they make [nursing care] sound. That you, and you alone, are responsible for people's lives. It's hard being these burgeoning nursing students with no experience and yet at the same time being told that you need to know these things which you really can't know without experience. It's frustrating for me, and I always wish I was second graduate from nursing school with ten years [of experience] under your belt.

At the same time, they would tell the researcher that they cannot learn those skills outside of the clinical practice setting.

Student: You can't sit in the classroom and learn and say "well, this is the nursing care that needs to be done." It's when you go in the floor [clinical unit] and find out how it's really done and actually get your hands in it.

An implication of the doing so here goal for the students was that, in order to accept the responsibility of patient care assignments, they moved out of the role of student and into the role of nurse. To the students, a student role implied that mistakes were acceptable and learning by trial and error was also acceptable. As students, they were responsible only for themselves, their learning behavior had consequences only for their own life. As nurses, they were responsible for another person's life and well-being.

Student: There's so much at one time. And the responsibility. It's not like it can be here and you can say "I don't like that sound" and just ignore it. You can't do that. You have to maintain that integrity at the same time. I think that can be very stressful.

If it came down to a choice between risk to the patient and risk to the student's grade or self-concept, the student would risk looking stupid or incompetent in order to protect the patient.

Student: When it comes to health and the patient, they take first, before any instructor, because that's my responsibility for that day.

Student: I let people know when I don't feel competent in a situation. And I don't care whether they think I'm stupid or not. I'm not going to take those risks because I don't think that's right for me or for the patient.

Student: I feel that it's better to get caught making the mistakes [not looking good as a student] than to get caught making a mistake because you didn't. So I would rather seem stupid than compromise my care of the patient.

The setting in which the clinical practice took place could facilitate the student's accomplishment of the do no harm goal. The setting used for this study was a very open area. The nursery rooms were large, and there were normally several staff members present in each room. There were also windows in all walls so that what was happening in the room was visible from the hall, the nurses' station, and the two adjoining nurseries. Rather than causing students to feel constantly on display, this openness seemed to engender a sense of safety and security. The student's fear of harming a patient was decreased by the perceived rapid availability of help.

Student: It helped some to work in the room that I ~~WORKED~~ in because there was someone in there with me part of the time, and I was close to the nursing station. I just felt a little safer there than if I had been off in an isolation room with the door closed or something where I would have felt like I wasn't within easy access of some help. So that made me feel more comfortable.

Another student was left alone with her patients most of one day because the patient census was low, and the one staff nurse assigned to this room was also assigned to patients in other rooms. Rather than giving the student a feeling of independence and competence that might come from being trusted with the patients, this isolation created anxiety that a patient might be harmed.

Student: I was in there by myself and it kind of ~~WORRIED~~ me. Maybe they'll choke or something will go wrong with their heart, and I won't be able to know about it until it's too late.

The incidents of potential patient harm that the students described in interviews were relatively obvious. During these incidents there was some sign in the patient's behavior or physiologic response that was difficult for the student to ignore. While it was

always the students' intent to protect the patient from risk due to their relative inexperience and lack of knowledge, both students and instructors were aware that the students did not always have the clinical judgment to discern when a patient was at risk. Sometimes it was the students' lack of knowledge that led to a patient risk that the students did not recognize. The risk might be called to their attention by someone else in the environment as in the situation recorded in this excerpt from field notes.

Instructor to student: "Do you have a clamp in there for the control vital?" Student shakes head negatively.
Instructor: "If your patient's control line came undone, what would you do?" Student (After some hesitation): "I guess I would pinch it off with my fingers until I can get some help." Instructor: "You should have checked this morning. How King Nurses are back here today? There's just one. What if she sneezes's come? What would you do? That's an active child. Have you thought about what you would do?" (The replication here was that the child could bleed to death). Student: "I can see it would be more efficient to use a clamp. As time goes on I realize how important it is. I can't believe I didn't think about it."

Later, in an interview, this student remained convinced that she should have known that she needed a clamp and was distressed by the idea that she might have created an unnecessary danger for her patient.

As the student perspective is described, it will be apparent that all of the goals interact. They cannot be considered in isolation from each other. This first goal of doing no harm, however, had the most pervasive influence on all aspects of the students' behavior in the clinical area.

Helping the Patients

The second goal was closely related to the first and, in many situations, was difficult to separate from the first. The students wanted to help their patients by making some positive contribution to their assigned patients' nursing care. For the students, clinical experience was much more than an opportunity to learn. Working with patients in a clinical setting was the students' opportunity to begin helping people. The students' goals and motivation for choosing nursing as a profession were a major factor in shaping this goal.

In response to an interview question about how she decided how well she had performed on a given clinical day, a student said:

I did something that might not have been done [for the patient] if I hadn't been there. I felt good that I was the one that did it.

The clinical experience was a successful one if the student was able to help the patient. The students might acknowledge that they had learned new skills or concepts, but they would not leave the clinical area with a sense of satisfaction about their clinical experience unless they had accomplished something positive for the patient.

Student: [When I evaluate myself] I look at "did I really do anything for that patient? Did I find nursing services that they really needed, or was there a dramatic change in their breath sounds because of the [chest physical therapy] I did approximately that day?"

Student: I want to be good. I want to take care of my patients well. I want to make a difference in their stay in the hospital so that it will be a healthier one and a more pleasant one because they're important to me.

The student wanted to make an unique contribution to patient care. She wanted to do something an nurse else thought to do or would take the time to do. The contribution she made to the patient's care

was a partial justification for her presence on the clinical unit. She was doing more than just practicing on patients. This student was asked how she knew whether or not she had done well in the clinical experience that day.

Student: If I feel I'm doing good for the patient. If I see some sort of improvement, or I know something important and I do something about it. If I just do procedures that are going to be done anyway, I don't feel like I've accomplished anything.

This need to be needed was included in the criteria for achieving the goal of looking good as a nurse. The students wanted to be involved in clinical experiences like the one described next. When the students were part of this kind of situation, the patients' responses became a type of feedback about the students' competence as nurses.

Student: I think when I get positive reactions from a patient--that always makes me feel really good, whether it's just be a "thank you for helping me today" or if it be like--I had a patient that started having congestive heart failure and we initiated all the proceedings, the Lasix and by the end of my shift he was doing a lot better. And I walked away feeling really good because I had helped to turn him around. On just an 8-hour shift he was doing a lot better. I think the positive kinds of reactions are nice. They help us to say "well, I might not be so bad after all."

Student: A lot of times I leave clinical feeling competent about myself because I took care of this patient to the best of my ability and that I made them as comfortable as I could or I helped them. So that makes me feel competent. A lot of times I feel a lot of self-satisfaction from the way I make patients feel.

Unlike the first goal, doing no harm, the second goal did not necessarily justify the student risking her goal of looking good as a student. The student might try to accomplish both goals by using resources other than the instructor for help. The patient was then cared for appropriately, and the student avoided a threat to her

looking good as a student goal. In response to an interview question about who was the best person to ask for help in the clinical setting, this student detailed a list of who she would ask for what information or help. The instructor was not one of the persons listed that the student would approach for help.

Researcher: Are there any things you would ask your instructor?

Student: I don't like to ask the instructor very much at all. I don't like to ask the instructor. Well, first I would ask all my sources and then I would ask my instructor.

Researcher: Do you tell me the reasons why?

Student: Yes. I had an instructor once that--I asked her and she said it against me. It came back in my evaluation.

This student's actions in seeking help were clearly aimed at both helping the patient and looking good as a student. For this student, asking questions of the instructor was a risky strategy.

As the students approached graduation the reality of their immediate future made this patient-related goal even more important. The student role was about to end. This student was approximately four months from graduation when she was interviewed.

Student: The goal [of completing nursing school] is ~~becomes~~ something much more concrete. I want to be able to take care of patients that I'm required to take care of, and I want to do it safely. It becomes more real as the time goes closer. Junior year it's far away.

Almost all of the students, when interviewed, asserted the belief that the patient always comes first.

Student: I always think about my patients first.
~~That's~~ Number one. And then you work back from that.

Without appearing to be aware of the contradiction, many of the students would later qualify this goal. Helping the patient was a clear student goal, but it did not occupy the same place of importance

is influencing student behavior as did the goal of doing no harm. In the following excerpts from an interview, the student set conditions on what kind of patient assignments she wanted. The researcher had asked her to describe her *love* patient after the student had said that she performed much better if she had her ideal patient.

Student: [My ideal patient] is just someone who is accepting of the nursing care, made out of the environment of being in the hospital, but at least that they acknowledge that you're there trying to help them whether you do or not--that you're there to help them.

This implied that patient responsiveness had an effect on the student's pursuit of the helping patients goal. The goal of looking good as a nurse, which will be described later, was more important to this student than the goal of helping patients.

Integration of Theory into Clinical Practice

The students in this program had spent at least two years before beginning the nursing major taking basic sciences and other prerequisite coursework. They were taking, concurrently with this clinical course, a six-credit hour course, Health Problems I. In Health Problems I the students studied in a classroom setting the common physical health problems of adults and children. The student was, at the same time, expected to translate this classroom theory into practical use in a variety of clinical settings. Almost every student interviewed commented in some way on the process of transforming facts and theories learned in a book or classroom into meaningful concepts in the day to day nursing care of their patients. Students noted that some concepts were much more meaningful when they were encountered in

the clinical setting. "It's just a diagram when it's in the lecture."

Using the ideas presented in the classroom in a clinical setting

increased retention of the newly learned concepts and theories.

Student: I learn much better if it's taught to me in class first, then I go on the floor and I say "Okay, there's a little kid with leukemia, now this is what's going on with him." And relate it back to what I learned in class and that way it sticks in my mind. If not, I don't retain it.

Student: I'd just about rather have less class time and more clinical. Even those two days, even the days I made mistakes, I learned so much being on the floor. All the telling you this is nothing until you see someone having this problem. Then you remember it forever. If you see someone just having a stroke. If you can see the signs and symptoms, you're right there. It's real, it's not just a story to be and you get a total picture.

Student: You can learn so much in the classroom and then you're going to go out and forget it. After a few months I'm sure that we're not going to retain this material [from lectures and assigned readings]. But actually I learn so much more by doing things than I do by just learning in a classroom. So I think maybe we should have a little more clinical time.

The clinical experience time appeared to be the primary arena for learning both theory and clinical skills.

Student: Most of the learning takes place when you get a little bit of the theory behind you and you need to do it to keep it.

Student: Having a patient with a disease provides teachers at more than sitting in class and learning about it.

The content of the theory course rarely paralleled the clinical experience because of the need to place students in a variety of agencies and relate them through a series of different settings in the course of the semester. For example, it would be impossible to provide 75 students with the opportunity to care for a premature infant during the week prematurity was the classroom topic. The

students near the end of the term were delighted when patient care related directly to something they were studying in the classroom, while students at the beginning of each term were frustrated by the fact that they had not yet had any of the lectures on pediatric health problems.

Student: She was a complex patient and she had a lot for us to learn from and I thought it was really neat that I could understand things from class that we talked about that related directly to my patient.

Student: I feel that clinical is very important. I feel that this is where you're learning and everywhere I've taken a test I've answered those questions, not from what I studied in the classroom. I answered them because that's what I did on the floor.

The following excerpt from an early field note catches the frustration students experienced when the classroom context did not parallel what they were expected to do in clinical experience.

After I walked out of the room at the end of my observation, one of the students stopped me when I said goodbye. He wanted to talk about how different this was from working with adults. He has never worked with children before except for two days in the newborn nursery last year. He said that they haven't had the classroom content on pediatrics yet and that every child seems to have as much wrong with it. He said they spent all of last evening with Denise's [Teacher of Pediatrics] trying to figure out what to do with their patients. He says they feel like they don't know how to do anything up here.

Learning Raising Clinical Practice Skills

An important, and often controversial, part of the clinical experience was the learning of psychomotor skills. Educators, citing the futility of trying to teach every student every skill they might need to perform when they graduate, tend to concentrate on teaching students the basic principles that form the rationale for technical

skills. Nurses in nursing service, facing the need to orient new graduates, across nursing education of living is an ivory tower and want new graduates to come to them with greater competence in technical skills. The students, who frequently identify nursing with these highly visible skills, expressed frustration over what they perceived as inadequate skill practice. When asked in interviews how they would alter the clinical course to improve their learning, most students replied that they need to learn more skills, that they needed more clinical time.

Students centered much of their behavior in the clinical area around the learning of technical skills. When students were asked what they had learned that day or week, they usually listed the technical skills they had done for the first time or were able to do without help for the first time. Further questioning elicited descriptions of learning about other aspects of nursing, but the fact that skills were usually mentioned first was an indication of how important this goal was to students. Although nursing clinical practice skills are not limited to psychomotor technical skills, it was these psychomotor skills that were the core of this goal. Some students mentioned the importance of developing good communication skills, but their primary focus still appeared to be psychomotor skills.

Student: I mean we're up there to learn skills.
That's the whole point of clinical--to learn this stuff,
there on the scene.

Student: Skills are something I feel like I need to do a
lot of right now as a student.

Student¹: There's only so much you can learn from books. You can read all the steps in a procedure but until you do it.

For the students, the clinical experience was more important for the learning of skills than the learning of theory. In the students' view, skills could only be learned in the clinical setting. The students agreed that psychomotor skills were easy to master but mastering one skill did not decrease their anxiety about the next new skill.

Student¹: I learned just plain old normal care of DVTs² which is something that is very often to me not having any of my own. I got to watch someone take care of a child with a trach and do suctioning which is something that has always kind of terrified me. When you see new skills being done, it takes it out of the twilight zone and you realize the "oh, I can do that; that's not so bad."

Student¹: I got most of my skills—like after we've learned one and since we choose our own patients—I get patients I can do the skills on instead of going up to the skills lab.

When students talked about needing skills practice during an interview, they almost invariably realized their focus and would then tell the researcher how important it was to incorporate theory into practice. These statements were probably honest although certainly influenced by the socialization process they had undergone in a year in this nursing program. The students had learned the theory and had come to believe that theory was important. However, their observable behavior in the clinical setting was still primarily concerned with skill performance.

Student²: I think in order to be a good nurse you need to know the theory behind things so that you can just incorporate all this into your patient care instead of just incorporating skills because you need contact with the patients more than just do the skill and leave.

When the assigned patients required psychomotor skills that the students needed to learn, the students then were able to focus on other aspects of the nursing care. Knowing that they were learning new skills freed them to concentrate on other aspects of the experience.

Student: It's a teaching hospital. You have people coming from all over the world with all these different diseases. You've got the variety to pick your patients with the disease that you need to study and be able to help you and back you up on what you're learning in the classroom. You can't sit in the classroom and learn and say "well, this is the nursing care that needs to be done." It's when you go on the floor and find out how it's really done and actually get your hands in it. . .

Student: From a student's point of view a good patient is someone who has a lot of things that you can do that aren't really complicated and difficult--just a patient that's going to be a good learning experience. That has a disease process you want to learn about or a procedure you've never done before or is a different age that you can relate to. Just a patient who is a good learning experience.

Looking Good

Looking good was a essential part of the process of becoming a nurse. The students needed to look good academically in order to get good grades and to remain in the program. They needed to look good to instructor, staff, peers, and patients. This provided some of the positive feedback that helped them to develop the inner sense of competence and confidence that they would need to practice nursing. The students needed to look good to themselves. During early data collection this need to look good appeared as a single goal but, as data collection and analysis progressed, it became obvious that one general goal of looking good did not provide adequate explanatory

poor for the behavior that was observed. Looking good occurred as two goals; looking good as a student and looking good as a nurse. The students frequently used very different, even contradictory, behavior to reach each of these two goals.

Looking good as a student

The student wanted to look good to the instructor because of his perception that the instructor was always collecting evidence for his grade. Students were constantly aware that they were being evaluated, that is a few weeks they would receive a grade. Although they were graded on a clinical evaluation instrument (appendix D), they were frequently uncertain about just what knowledge or behavior the clinical instructor might be expecting, and they were very aware of the evaluative aspect of student-instructor interactions. There was a continuing process of finding out what the instructor wanted.

Student. The first week is always sort of iffy because you don't know what they want out of you.

Regardless of how good students felt about the quality of the nursing care they were providing patients, the sign of a good student was still a good grade. Students had been socialized into what Becker, Geer, and Hughes (1960) have called the gradepester perspective long before they were admitted to the upper division nursing program. In a typical response, a student told the researcher, "I gauge my status as a student by grades." Some students, having heard that the nursing program is difficult, attempted to readjust their perspective about grades.

Student: I'm really grade conscious now. More than I was in the beginning, because in the beginning of the junior year I thought, "I'm really in a tough course now, and I can't expect to make grades as good as I have been making. So don't worry about it." And I hoped out that I did do pretty good. So now I've got something to uphold.

During interviews, the majority of the students alluded to some standard of perfection expected by the instructor in evaluating their performance. Components of this standard appeared to be answering all questions correctly, making no mistakes in skill performance, and always being involved in learning activities. At the beginning of an observation period early in a shift, the student said to the researcher

I'm just trying to get oriented. It takes me a long time. I just hope I can figure out everything I need to know before my instructor arrives.

Having the right answers in the student-instructor interaction was the most commonly identified criterion for looking good as a student.

Student: I hate it when they [the instructor] ask because I'm always afraid I'm not going to know, but if I answer right, then I feel really great.

Student: I was helping Ann and Barbara do their IV tubing change and the instructor asked me questions. She'd ask them questions and they didn't know the answer and then she'd ask me and I'd know the answer and that felt good.

The students believed that almost every answer and action during the student-instructor encounter was going to delete or add points to their final grade.

Student: There's just a lot of pressure here. Like you have to do it right, and if you don't points are taken off your grade. Now try not to think about it. You try to think about the patient, but you can't help it when you know the instructor is around, and they catch you on stuff.

Since every moment counts, the student who had a bad day needed to work even harder the next day to make a good impression on the instructor and recover the points she had lost.

Student: I felt like I had really made a bad impression the first week, and I really had to do some catching up.

The student not only had to care for her assigned patients appropriately and answer all the instructor's questions, but she also had to show that she was making the effort to get the most value out of the available learning experiences.

Student: The teachers want to know that you're not trying to give yourself an easy ride. That you're going for the good learning experiences, and you're trying to challenge yourself.

Instructor: Is it okay to have nothing to do? Or are you supposed to use every single minute of class? *Student:* No, it's not okay. You'd better be doing something. No, that's not good. There's always something you can do. And you'd better find it. No, if your teacher time is and now you hanging out—that would be bad. That would be very bad.

The goal of looking good as a student guided the students' interactions with their instructors. "You definitely try to impress your instructor." Students approached or avoided instructors based on how confident and competent they felt.

Student: I avoid teachers because I don't want to get caught not knowing something.

Student: It's usually easier for me to leave from nurses than it is our teacher because I'm so scared. Because [the instructors] ask questions all the time and I'm afraid I'm going to say the wrong thing.

Student: In describing who she got answers to questions from: Usually I don't ask the instructor because she's not there, and when I catch her and ask her she is going to ask me a bunch of questions, and I don't know the answers at . . . I usually ask the nurses.

Academically, students approached the clinical experience as a examination rather than as a learning experience. More specifically, they approached the student-instructor interaction as an examination. For many of the students, learning in the clinical experience took place outside the context of the student-instructor interaction. Even those students who appeared more confident about themselves as students and nurses were concerned about evaluation. This student summed up the conflict the students experienced between the demands of looking good as a student and looking good as a nurse.

Student: Would I have said anything that might jeopardize my grade? Because my grades have been real important to me. They're more important than I wish they were actually. Because I'm realizing now that what really counts is to know what I'm doing as much as I can when I get out of here. Sometimes that doesn't always fit the same needs as when you're trying to get a good grade.

The goal of looking good as a student had an effect on the ways students structured the process of learning in the clinical setting. The effect of the nursing student perspective on the learning process will be described in Chapter Five.

Looking good as a nurse

The second looking good goal was associated with the student's need to acquire an inner sense of competence as a nurse. This goal was closely related to the goal, helping patients, in that the feeling of accomplishment that resulted from helping a patient contributed to the student's growing sense of competence. Achieving the goal of helping patients was one way to look good as a nurse.

Student: This was year I had the first week was very hard, and no one could really take the time to sit there

and communicate with him since he was very hard of hearing. You have to write things out, and then he has to talk back, and he sort of resisted me. Not very many people had taken the time to sit down and discuss things with him, and I had the opportunity. I had to ask him some questions, so I got in talk to him and we got some communication going, and he expressed some things to me that he hadn't told anyone else. That made me feel really good, because I thought I had helped him. And that makes me feel good.

This student achieved the goal of helping a patient. She made an unique contribution to patient care. When she evaluated her clinical practice experience for that week, she was able to point to this incident as evidence that she was skilled enough to have a positive effect on patients' lives.

Other components of the clinical practice experience contributed to achievement of the looking good as a nurse goal. Successful performance of some aspect of nursing care that the student has not done before added to his sense of competence.

Student: I feel like I'm progressing when I can do something for a patient that I couldn't have done before.

Student: I go on skills a lot, because that is my weakest area. Sooner I do it smoothly, without mistakes.

Looking good as a nurse included the student's organizational skills. The students were usually assigned to give care to two patients at a time. Some of the nursing care was very familiar to the students, but other aspects of care might be completely new. Organizational skills were complicated by the brief time spent on any one clinical unit. Students usually worked only two days on the clinical unit in which this study took place, and much time was spent just finding supplies and equipment and learning the routines.

Reinforcing organization and a schedule was therefore an ongoing problem as the students moved from unit to unit.

Student: If I manage to stay on schedule, then I feel fairly decent.

Student: I always feel like I'm not good because I'm not employed.

The expectations the students brought to the nursing program might serve as a measure of how well they were doing. These expectations would vary from student to student based on their background exposure to nursing.

Student: I feel that, well thinking back to last year, I expected by the end of my senior year to feel a lot more competent than I do. I still feel incompetent. I still feel I need a lot of help.

The students examined their own feeling of comfort and competence in the midst of the clinical experience and used their level of anxiety about performing nursing care as a measure of their competence as a nurse. When their anxiety level was low and they felt comfortable doing the nursing care, the students felt an increased competence.

Student: I evaluate myself by how confident I feel. If I can handle everything without getting really upset or uptight or blowing something, I'm okay.

Student: The parents looked at me like they wanted me to help them out and tell them what to do. It puts you more in a role when they're asking you what to do than someone looking at you to see what you're doing wrong.

Student: I felt like this week I worked a lot more as an independent real nurse, not just as a student because I was pretty much in charge of those patients completely, and the nurse wasn't even involved, and when the doctors came in and say something, I was the one who told them what was going on. Parents called. I was the one who talked to the parents. I felt really good. It felt like—not just a student. My input here is valid.

Feedback from staff nurses had an effect on the students' sense of competence. Verbal feedback from the staff nurses was almost exclusively positive in this clinical setting. Because the staff nurses did not have a role in assigning a grade to the students, their feedback served as evaluation of the looking good as a nurse goal.

Student: [The staff nurse] said a couple of things to me. She said that I had done a good job with Lynn and if I could deal with a patient like Lynn, I could deal with any patient. And then she told me again when I left that I did a good job.

Student: There have been times when I've been glad the nurses didn't say anything to me—I didn't want to hear what they said—really rough day.

In the following situation, not only did the student look good as a nurse but, because the feedback was also given to the instructor, he looked good as a student.

Student: I got encouragement from staff a lot. The nurse I was working with last week said that she told my instructor that the baby was a difficult feeder, and I was getting her to take everything. That really made me feel good.

Indirect feedback from the staff nurses was important in achieving this goal. When the staff was accepting of the students' presence, helped them willingly, and made them feel like part of the health care team, the students' sense of competence was increased.

Student: I worked with one nurse in particular who really gave me a lot of confidence. She helped me a lot. In my learning because she gave me confidence and said, "Yep, you know what you're doing. Go out and go for it." It made me feel better and I learned more around her. Not only my own patient. I went to help other patients and did other things for her for patients other than mine.

The students were very clear in their view that there were two separate sets of criteria for the evaluation of their performance in the clinical setting. Evaluation of student performance was

evaluation by the instructor which resulted in a grade. Evaluation of nurse performance was evaluation of the quality of the nursing care the student delivered to his patients. Evaluation of nurse performance was primarily self-evaluation based on the kinds of environmental and internal evidence already described.

Student: I find that as time goes on my clinical grade ~~differs~~ less to me even though I've always done well, gotten A's or B's. But I don't feel that the interpretation that a teacher puts on me is going to put me in a box because I know what I do. Obviously the grades I put in my classes will do better on when they're not as good as I want them to be. It's funny that there's a discrepancy there.

Student: There have been times when I thought I did a good job as a student and not a nurse, and that's probably when you're thinking about your care plan that's due the next day or two days from then.

The grade for the clinical course was the evaluation of their student role, and students perceived that it was based on how well they answered the instructor's questions and on how well they did with charting and written care plans. As the students felt more competent in their nursing performance, they were able to discount the impact of the clinical grade as the goal of looking good as a nurse.

Student: I don't think I gauge how good a nurse I'm going to be by my grades at all. I definitely have two criteria as far as being a student and how well I do on the floor.

Student: I could feel good about the care I had given a patient even though I didn't know the answer to a question the instructor had asked. It's different.

Student: I look at how I feel rather than what my instructor says.

Notes

Student Roles

The six goals—do no harm, make a positive contribution to patient care, integrate theory into clinical practice, learn clinical practice skills, look good as a student, and feel good as a nurse—form the framework of the perspective which guided the students' behavior in the clinical practice course. The focus of the goals and the students' action was on two discrete aspects of the students' perceptions of the clinical experience and on their role in that clinical setting. The second part of the nursing student perspective is the students' perceived role in the clinical practice setting. What position or role was appropriate for a nursing student given the educational setting and the six goals? Just as the students clearly had two sets of criteria for evaluating their performance in the clinical area, they had two roles to fill. They were students, and they were nurses. They did not occupy both roles at the same time but alternated between the two roles. The currently predominant goal would determine which role the student occupied.

The first role, that of student, was fulfilled primarily by work outside the clinical setting. The student role consisted of those actions directed toward nursing care but not the actual nursing care. Reading, preparation of nursing care plans, and practice in the skills lab were part of the student role. The student role also included much of the student-instructor interaction in which the student was concerned primarily with the goal of looking good as a student. Students developed a repertoire of actions that were intended to

increase the probability of looking good as a student in the student-instructor interaction.

The second role that students assumed in the clinical area was the nurse role. This role was closely associated with the goal of helping the patient and seemed to have a far greater effect on student behavior in the clinical area than did the role of student. With the exception of the relatively brief time that the students spent in the presence of the instructor during a clinical practice day, they were in a nurse role.

In clinical education, the learner is providing the very services he is learning to provide. This is very different from the traditional academic setting where experimentation and trial and error learning are frequently encouraged. The culture of schooling is one in which mistakes have consequences only for the student. If the student failed a test in a traditional academic course the consequences might include embarrassment, lower grades, delay in graduation, or a change in career goals. Academic failures did not have a direct effect on the life and well-being of another human being. Because other people were affected in clinical practice courses, the learner tried to organize his approach to the clinical practice environment so that he was in a nurse role when the patient was directly involved and in a student role outside of his nursing care activities.

Student: It's weird, you get caught up in the function of a nurse and of a student... I tend to function up a nurse. You've got this patient who needs this, this, and this, but you get caught up sometimes as a student in this you've got to satisfy your professor and your patient. I find that I work much better if I do the nursing and first

and then fill in with my professor. It makes the role of the student work secondly.

Staff expectations of students also contributed to the delineation of the roles. While acknowledging that the students were there to learn, the staff nurses made it clear that the students' obligation to their patients had priority over optional learning experiences.

Student to staff nurse: "I'm going to watch [the physician] do that procedure [abdominal tap]. He: 'Good [check and record] the I&O [intravenous fluid] administered with an infusion pump' First, he gives a check."

Within this role structure, learning and looking good as a student were not synonymous. Learning might be directed toward the nurse role, and looking good as a student did not necessarily imply learning. Looking good as a student was a type of self-presentation where it was not so much what you knew that counted, but rather what the teacher thought that you knew. This style of self-presentation had been developed over the course of the students' academic career and was modified to fit the new expectations of a clinical course. The students discovered that although they were still students and were completing course requirements, they were in a setting where they must try to balance the demands of two roles that might have competing or conflicting requirements.

The students believed that, while they are in the clinical practice environment, the nurse role was the more important role. They might have to relinquish actions directed toward meeting the demands of the student role in order to meet the demands of the nurse role. Because of the relative importance of the nurse role, students

were willing to straddle their clinical learning experiences in ways that were threatening to the traditional student role. Asking the questions that were essential if the student was to provide safe, adequate care was not consistent with presenting a good front as a student. Self-presentation as a student, looking good as a student, involved finding out what the instructor expected and convincing her that you had achieved those expectations. The students' first choice of action was to meet the demands of both roles. Whenever possible they tried to provide good patient care and to look good as a student. One method of achieving this balance was to go to the nursing staff with questions and for supervision of skill performance. Whatever the staff observed about the student's performance did not become part of the evaluation of the student as student. The students felt free to be learners. They could reveal their learning needs without fear of threat to their grade.

Student: It's really easier for me to learn from nurses than TC is our teacher, because I'm so scared because they ask questions all the time, and I'm afraid I'm going to say the wrong thing.

Student: I know I kind of avoid the teachers because I don't want to get caught not knowing something. I go to the nurses more because I know I get the same information from them that I get from my teacher, and it won't be as stressful. I usually learn better that way.

In the students' view, the staff expectations of their behavior were not as great as the instructor's expectations, and the students therefore felt less stress. The decreased stress was a result of the students being able to focus on only one role. The students often experienced so much stress in trying to meet the demands of the student role that their performance in the nursing role was affected.

Student: I just fell out on the spot and I would find myself concentrating more on trying to figure out how to answer the question instead of doing what I need to do.

Student: [When the instructor comes in] you're in the middle of something and you lose your train of thought and that's not good either because it's taking away your concentration on what you're doing.

Student: It [persistent questioning] disrupts everything you're doing. It disrupts your concentration. It disrupts what you're going to do next and then for the rest of the clinical day you're shut because you don't think you're doing anything right.

Students preferred to keep the two roles separated. They preferred to do the nursing care first without the instructor present. When the nursing care was complete and the student's obligation to the patient was met, the student was ready to step into the student role and show the instructor how much he knew.

Student: I find that I work much better if I do the nursing first and then roll in with my professor.

Student: Sometimes I will think, "well, you can be a student now. I have all my nursing work done. I can go find my instructor and talk with her."

Instructor Role

The nursing student perspective that shaped the students' learning behavior in the clinical area also included their ideas about the role of the instructor and the staff nurses in the process of student learning. There were several aspects of the instructor's role that affected the learning climate of the clinical practice setting.

Evaluation role

Evaluation was the most frequently mentioned aspect of the instructor's role in the clinical practice course. Because of the goal of looking good as a student, students approached most student-instructor interactions with the instructor's evaluative function foremost in their thoughts. From an observer perspective it was not clear when the instructor was asking questions primarily to determine learning needs and when she was collecting data for the purpose of assigning a grade. The students had the sense that the instructor was always evaluating and moreover could remember everything that the students said or did.

Student: I don't know if they're trying to teach us or not. I think they get you to a point and then when you don't know they'll call you. They'll question you to the point of not knowing and then they'll call you. But they're evaluating the whole time. I think they evaluate everything they're around you. They remember things. I feel a lot more comfortable when the nurses.

Student: They're evaluating everytime. Even in situations she claims are not grades.

Student: We've got to be on our toes as far as being watched by the instructor.

Student: I think they're out there starting the information they get from you. Later on when it comes time for evaluation they think back and bring up the points.

A few of the students described student-instructor interactions in adversary terms. These students were involved in a context where the student tried to look good and the instructor tried to make the student look bad.

Student: Usually when [the instructor] comes up to you [in clinical interactions] they've got their guns cocked and ready to fire.

Student: [The instructor] wanted to make you really nervous and it seemed like she had this attitude that she was just waiting for you to mess up so she could get you...

Evaluation was viewed in negative terms. The instructor was looking for evidence that the student had not met the course expectations.

Evaluation was rarely viewed as a formative process that helped the students to improve their nursing practice.

Researcher: Are the instructors always evaluating?
Student: I would think so. They observe what you're doing and how you're doing it. I don't think they're always consciously doing it. Saying "well, she is doing that wrong and this is bad." But I think they're out there storing the information they get from you. Later on when it comes time for evaluation and they think "well, did she do that?" And they think back and bring up the point.

Student: I'm afraid they'll say "well, you should know that." And if I should have, I would have. So I'm afraid they'll keep it against you and remember in your evaluation because they remember minute things.

During observation the researcher usually was not certain when evaluation was taking place. The student perception that instructors were always evaluating was based on this lack of clear separation of evaluation and teaching as well as on the students' experience of previous clinical evaluation conferences.

The instructor and student came into the room. The student is carrying two syringes. Instructor: "Now when you give the shot where are you going to give it?"
Student: "Right here in the leg." She has hands over the area.
Instructor: "Take them off and feel them and tell me where you want to give it."

In this situation the instructor could have been evaluating the student's skills in doing this procedure in order to guide the teaching, to give the student a grade, or to ensure patient safety. Because learning time and evaluation time were not clearly separated, the student had the stress of not being sure if she was being graded.

She needed to look good all the time. Her performance needed to be perfect whenever the instructor was present.

A similar lack of clarity of purpose occurred when the instructor asked questions such as, "Are you caught up?" The instructor might just be checking to see if the student needed any assistance with the work that must be done before the student left the unit because the instructor had a responsibility to patients and staff. Perhaps the instructor really was asking if the student organized adequately to have all of her patient care and documentation done. The students associated organization with competence and therefore with looking good. It was important to be able to say "yes" when the instructor asked if you were caught up.

Even those students who were able to say that the instructor was not always evaluating eventually revealed by their words and actions that they simulated their encounters with the instructor with the evaluative function in mind.

Student: I knew that the teaching I would get [from the instructor] would be tinged with being evaluated so I don't know if that would interfere with how many questions I would ask or how hesitant I would be to show my incompetence.

Student: A lot of times I feel that they're just there to evaluate at all the time, but I think they're there to give us support in some areas that we're not so competent at.

In most interactions the students had difficulty knowing when the instructor was evaluating and when she was teaching. Many situations were ambiguous, but the students were fairly certain that when the instructor was actually demonstrating a skill she was teaching and not evaluating.

Student: She would evaluate us when she would ask us the pathophysiology of our patients and what we knew about them or she would ask us "since this [is what is happening], what are you going to do?" and more in the teaching would be when she would show us dressing changes.

The student stated in an interview that her instructor's questions were not always evaluative and that she usually knew when she was being evaluated. Her description of the way to distinguish between evaluation and teaching was an indicator of the vague interactional cues that students tend to assign meaning to the instructor's actions.

Researcher: How can you tell the difference between questions that are intended for teaching and questions intended for evaluation?

Student: When she's asking questions and not teaching, she's looking down at her paper and writing. When she's asking questions and teaching she has eye contact.

Teaching role

The evaluative aspect of the instructor role was associated with the student goal of looking good as a student. Teaching, the second aspect of the instructor's role, was related to the students' learning goals. The students' first learning goal was to integrate the theory and concepts they learned in class into their actual clinical practice. The instructor, with these students who could see beyond her evaluative function, facilitated this integration.

Student: We have a lot of theory when we go in there [clinical practice site]. I think the clinical instructor is helping us shape that theory into actual clinical practice.

Student: We've had some of these things in class but, you get there and you don't really think of it. It's not all

to the forefront of your mind and [the instructor] helps you get everything to the forefront.

When the students could see the instructor as a facilitator of learning, the instructor's questions had a purpose beyond evaluation.

Student: [The instructor] asks questions to make us think.

Student: When an instructor comes in and starts asking me questions about the patient it really helps me integrate their disease process into the care. It brings me back if it's just caught up in the routine and that's really important. And usually when the instructor comes in and asks some questions it will lead me to continue thinking about it.

The students identified the instructor's teaching function much more with theory than with clinical practice skills although they did acknowledge that, if she was available, the instructor would help them with skills.

Student: We were pretty much limited to intellectual kinds of things [with the instructor].

Student: She [instructor] will help us--like if we have a ~~problem~~ she'll stand there and tell us what we're doing wrong.

Student: When things get a little complicated with patients and skills that I don't know, I tend to go to my instructor because that's her job to teach me things like that.

In defining the instructor's teaching function, the students frequently compared teaching from the instructor and teaching from the staff nurses. In these comparisons, the instructor was identified with the world of theory and the staff nurse with the real world of clinical practice.

Student: They [the staff nurses] are definitely more task oriented. [The instructor] is very theory oriented which is nice.

Student: We learn more back knowledge from our teachers and more applications, more what it is going to be like when we get out in the field from nurses.

Student: She [the instructor] is more oriented [than the staff nurses] to explaining the reasons behind all the steps [in a procedure].

Protecting the patient rule

The instructor's role with the students included protecting patients from the mistakes caused by the students' lack of knowledge and skill. The instructor did this by asking questions and by being with the students during certain procedures.

Student: A lot of times I think they're a kind of buffer between you and the patient. The patient looks at you in utter terror, your hand trembling as you hold the needle and having someone else there who definitely knows what's going on sometimes smooths relationships over a little bit.

Student: [The instructor] shouldn't be showing us much as watching and making sure you're doing it right.

Student: [The instructor] wanted to make sure all her students were giving safe care.

Student: I think [the instructors] are supposed to supervise us to make sure we don't make any mistakes that would be detrimental to our patients.

By placing the instructor in a protecting the patient role, the student was able to accept more easily the threat that the instructor's questioning presented to the student's looking good goal because of the clear priority of the do no harm goal.

Student: [The instructors] have to get you on certain points and they don't have that much time and they're running around and they want to make sure you're safe and competent.

Student to instructor: "A . . . earlier today my patient's parents were in the hall and heard you talking

at me and she [the patient's mother] wanted to know who you were and why you were yelling at me. I told her that you were my instructor and you had to do that. It was your job to yell at me."

Supportive role

All five students identified a supportive role for the instructor. In general these were the students who were more self-assured about their competence as nurses.

Student1: I felt that [the instructor's] role was to instill my competence and then expecting me to be competent.

Student2: I felt that because [the instructor] isn't always there that she trusts me.

Student3: Sometimes when things don't work the way I wanted them to or I've made a mistake and I feel like the whole world has just crumbled around my ears, [the instructors are] real good resource people to go to. You can go try on their shoulder and if you want to talk with them about a patient, you're really great with, you can sit down and talk with them and not lose the confidentiality that you try to keep on the patient's records.

Role model

In contrast to the evidence in the literature on instructor as role model, only two students indicated that they considered the instructor to be a role model. Even in these two examples, the students were describing partial role models. The student saw some aspect of the instructor's behavior that she wanted to emulate.

Student1: I think too they're a little bit of a role model. I've had various clinical instructors with different ways of interacting with the staff, especially the doctors, and I got to watch them and get an idea of how I want to do it in the future.

Student: I have really learned from instructor's assessment of a patient--things that I didn't pick up and it has helped me to sharpen up my assessment skills.

As was characteristic of the students who identified a supportive role for the instructor, the students who described the instructor as role model were more confident about themselves. As students became more confident, evaluation appeared to be less of an ever-present threat. One of the students who saw the instructor as role model was also willing to assign her control roles without putting evaluation at the top of the list.

Student: I think mostly they were interested in us looking and ensuring that the patients were safe and comfortable and above and beyond that they would just look at our overall performance and get an overall picture of what we did instead of looking at isolated incidents.

Staff nurse roles

Teaching role

It was the policy of the clinical agency in which this study was conducted that the staff nurses were not to have any teaching responsibilities for students in this course. It was inevitable, however, because the students had to work side by side with these staff nurses while giving care and, because the instructor was not always available to them, that the students would view the staff nurse in a teaching role. Because the staff nurse did not contribute to the students' grades, students frequently were more comfortable asking the staff nurses for assistance.

Student: The [staff nurses] tend to be very good about [telling] that I am a student and need just a little bit of extra help. They don't tend to judge as much as a teacher would.

The staff nurse created an atmosphere that either helped or hindered learning. The staff nurses on the unit where the study was conducted were described as being helpful. The students frequently compared the attitude of nurses on this unit with nurses they had encountered in previous clinical experiences.

Student: Some of the nurses would just completely ignore you. They don't like you there. The work is the key. I hated to go to clinical.

In the following typical excerpt from field notes, the staff nurse encouraged the student by offering constructive assistance and by telling the student that the student knew the really important things. This kind of teaching approach allowed the student to learn while continuing to feel good about her competence as a nurse.

The student is preparing to give medication through a nasogastric tube. Student puts down the side rail and starts emptying the bell tape surrounding the NG tube. *SN:* "You can just sit in bed if you want." *Student:* follows her instructions. *SN:* "It's the little stuff that's hard to figure out. The big things you can prepare for."

The students were more likely to see the staff as qualified to help them with skills than to answer theory oriented questions. In clinical practice the staff nurse dealt with the immediate situation. The instructor provided the integration with theory.

Student: The nurses do a pretty good job but they're more like "well, okay, put this tube here" and not like "you put this tube here because of."

Student: A lot of times a floor nurse gets used to doing things a certain way and that's just the way she does it and when I'm going to be shown something by that person, that's what I'm going to be shown. Not "this is why we do" but "this is how I do it."

The staff nurse was in the role that the student anticipated assuming in just a few months. Because the staff nurses were on the

scene, the students were likely to assume that the staff nurse knew what was best for the patient. The staff nurse was closer to the action than the instructor.

Student: We as I to go in there and screw up their system and do things differently.

Instructor: These people [staff nurses] who are out there and have all this experience aren't necessarily the best of the best, but still I tend to look up to them because they've done it.

Role model

This identification with the staff nurses made it more likely that a staff nurse would be a role model, although there was little evidence in the data from this study for widespread use of the staff nurse as a role model.

Student: Seeing a top notch nurse on the floor work with a patient is really a wonderful learning experience. Seeing how they relate and how they do stuff. There's one nurse on [elder pain unit] that is a recent DCM graduate. I learned so much just by watching her interact with patients. It was really helpful.

Student: I think there should be more contact with the DCMs and the staff that's there.

Importance of staff

The students as a group found the staff nurses on this clinical unit to be helpful and supportive. The staff support of the students extended to protecting the student from the instructor and making positive comments to the instructor about a student.

One day before an observation period the instructor stopped the researcher to say that the student assigned to the clinical unit was

having serious difficulty meeting the requirements of this clinical experience and would probably fail the course. The instructor had told the staff nurses about this and was expecting them to be more than routinely watchful. In the beginning of the observation period the student was not there. The instructor was rounding the bedside chart, and the staff nurse was giving a tube feeding to the student's assigned patient. Without being asked, the staff nurse told the instructor that the student had planned to feed the baby, had called the formula room a couple of times, but the formula had just arrived. Later, when the student came to the staff nurse saying that her instructor had told her to ask the staff nurse about the mistakes the student had made in her charting, the staff nurse was very noncommittal with the student saying, "I figured out what you had done." The staff nurses in general were very protective of students who are in academic trouble and rarely said anything negative about a student to an instructor. They were more likely to tell an instructor that a particular student did a good job with a difficult patient.

Protecting the patient role

Finally, as did the instructor, the staff nurse protected the patient from the student's errors.

Student: I could take [the staff nurse] to there [the patient's room when doing a procedure] and she would just be somebody to be there and just kind of oversee what you're doing and protect everybody involved.

Instructor: What kind of help from the staff nurses available for learning?

Student: The most helpful thing is if the nurse will talk us through it so that I can do it myself but I know that she's not going to let us make a mistake.

Summary

In this chapter the nursing student perspective, which consisted of goals, actions taken to achieve those goals, and perceptions of the roles of student, instructor, and staff nurse has been described. The goals have been defined as interactive and as having shifting priority. Still to be considered is the effect this perspective had on the learning process.

The learning process did not take place in isolation, but within a very complex social setting. The students had defined their own role within this setting and had developed actions for achieving their goals with this context. In the next chapter the process of learning that the students experienced will be described as well as the effects of the nursing student perspective on each aspect of this learning process.

CHAPTER FIVE

LEARNING WITHIN THE NURSING STUDENT PERSPECTIVE

A perspective provides a guide for a group's behavior within a given set of circumstances. Nursing students were found to have formulated six goals that became the framework for their perspective of clinical practice. In the investigation of the effects of the nursing student perspective on the process of learning in a clinical setting, the researcher assumed that the students' ways of behaving in relationship to other people in the social context of the clinical unit had the power to influence the learning process. A second assumption was that the learning of clinical skills was both cognitive and interactive. Before describing the effects of the nursing student perspective on the process of learning, it is necessary to define that learning process. In this chapter, the process of learning used by the study group of nursing students will be described. In addition, the effects of the nursing student perspective on this learning process will be discussed.

Both the components of the learning process and the effects of the student perspective on that process came from analysis of data gathered via participant observation and interviewing. The domain, *Ways that Students Learn*, served as the framework for the section of this chapter on the learning process. The second section is based on an examination of the interaction of two domains, *Ways that Students Learn* and *Goals of Student Goals*.

The Learning Process

The components of the learning process in the studied group of nursing students included a sequence of four steps. The four steps in the process were observing, rehearsing, doing, and evaluating. Each of these steps occurred in the context of the clinical setting, and progression through the sequence of steps was influenced by the nursing student perspective.

Observing

Observing was the students' initial contact with a clinical skill to be learned. Observing was a general category that included actual demonstration, videotapes or films, written material, lecture content, or verbal instruction. Not all of these types of models were adequate for every skill. The complexity of the skill appeared to be the biggest factor in determining the nature of the model the students required before they were able to copy the behavior. Observing could only occur when the student was receptive to learning. Mere presence of an observable model in the environment was not sufficient.

Observing outside the clinical practice setting

Lectures. Classroom presentations provided an opportunity for one kind of observing, but students pointed out that this type of model was often inadequate

Students: Clinical is where you really learn what was ~~presented~~ in class.

Student: Having a patient with a disease process teaches me more than sitting in class learning about it.

Student: All the talking you is nervous until you have someone with this problem.

Reading. The students encountered many clinical practice skills for the first time in reading either the assigned course materials or in the resource textbooks and journals the students used to prepare for a specific clinical experience.

Student: I had read that feeding is a problem for almost all infants who are sick so I read about how to stimulate—stroking the neck, blowing on their face, tickling them or anything to get them to wake up if they're lethargic.

This student was observed during the time she fed an infant and, although she did use some of the techniques she described above, she was so obviously nervous about holding this tiny infant that the infant did not eat well. In this situation, the student observed a written model, imitated the skills, but did not have an adequate model of the entire task. She did not observe a model of how to hold an infant in a comfortable position. Students viewed classroom and textbook models as the ideal that could not always be put into practice and needed to be supplemented by other models.

Student: The textbook way is ideal, but someone never will tell you that you can't do it that way all the time.

Observation by reading was often an inadequate model for clinical practice skills although reading might provide the model for a minor technical skill that required little manipulation.

Rehearsal in the clinical setting

Forbil. The observed model right be completely worked up in the following situation. The instructor began by asking questions which prompted the student to begin rehearsal, the second step in the learning process. Before the student could complete the rehearsal, the instructor interrupted her and completed the interaction by presenting a verbal model.

The instructor came into the room and came up to two students who were sitting at the table. The instructor has a sheet of paper in her hand. Instructor: "Have your assignments changed since yesterday?" Both Students shake heads no. Instructor: "Any [i]f's or anything I need to go over with you?" Student A: "I have a [nasogastric feeding tube]." Instructor: "Do you have to place one or just give a feeding through one?" Student A: "It's already in. We just give her feeding that way." Student B: "I have a gastrostomy tube." Instructor: "Are you going to do a dressing change or [i]ust feed via through it?" Student B: "No, just feeding. She gets [formula orally] or [infused] and then the rest through the tube if she doesn't finish it." Instructor: "Look in the procedure book out of the DSB for gastrostomy tube care. You can get a general idea. It's not very difficult. What kinds of practical things about it would you have to do?" Student A: "Well, the temperature should be close to body temperature and not too much on once and her tube is clamped off after the feeding goes in." Instructor: "The main thing is safety of the patient. THIS is a small baby with a small stomach. Don't force it. You'll see people use a plunger to get it started. It's not a real good idea but you see it a lot. And like you said the cooperative. Make sure you have the correct formula and check for leakage around the tube. I'm going to be next door and then I'm going to [other wing of this clinical unit] and then down to [other pediatric unit]."

Both the instructor's verbal model and the aspects of the procedure that Student B rehearsed verbally were available as verbal models for Student A.

The students sometimes requested a verbal model. The students did not want to miss any opportunities to perform skills and, if an

opportunity occurred unexpectedly, the students often would try to observe a verbal model from the instructor or staff nurse so that they could attempt the skill performance immediately.

Student: I have a nurse stand there and go through it, NOT DO IT, just talk about it. Then if I feel comfortable with it, if I feel, "okay, I think I can do that with my two hands and not have to worry," I will do it with her standing there. If I feel like "I'd better not, I feel uncomfortable, I want to see you do it first and then the next time it has to be done, get me and let me do it."

Many times variations of skills that students already knew in one form could be done with verbal modeling only. This student had already learned chest physical therapy with adult patients. Here the instructor provided a verbal model of a pediatric adaptation of this procedure.

Instructor: This is a necktie cap taped to a tongue STICK and placed so you can do chest PT. You could do it with your hand but your hand covers her entire chest. This way you can get the apical areas and under her arms.

Demonstration. Watching a demonstration was the most obvious of the kinds of observing. Someone with the knowledge of the skill (instructor, staff nurse, nursing assistant, or classmate) performed the skill while the student watched and, in many situations, asked questions.

The student is holding a baby and the instructor is changing the linen on the infant warmer. Instructor: "Does she stay up fairly well or does she SLURP down to the bottom?" Student: "She doesn't stay up very well." Instructor: "That affects the purpose of the tilted bed." Instructor then demonstrates how to use blankets to keep the infant from sliding down in bed. Also shows student how to put down side of warmer.

Student: [The staff nurse] did it [retrograde medication], BUT she showed me everything before she did it and afterwards I went over it with her. I felt I could do it myself the next time.

The individual demonstrating the skill might also talk as he performed the skill, either describing what he was doing or giving rationals for each action.

Student: I observe the first time, usually. Unless it's something simple. Then I have someone just talk me through it and I'll do it. If it's something that is either complex or I'm uncomfortable with, I observe first.

Student: The best way I learn things usually is if I have one of the nurses on the floor go through it one time and they tell me what they're doing as they're doing it. They're saying "do this and do this" and they're doing it. They just talk out loud as they're doing it and the next time they help me do it—that's the best way I learn.

Students who had observed a skill by instruction in the classroom or by reading a written model were frequently uncertain about their ability to copy the model. A demonstration model supplemented the symbolic model of the book or lecture, and the students reported greater certainty about their ability to attempt to copy the model.

Student: I learn a lot from watching the nurses perform things even though I know how to do it and I know the rationals behind it. I learn by seeing the nurses do it first and seeing their reasoning for doing it a certain way.

Student: When you see new skills being done, it takes it out of the textbook case and you realize that "oh, I can do that. That's not as bad."

Student: It helped me to see [the staff nurse] do it because I really didn't understand when the teacher was just explaining the concept of it [retrograde administration of D medications].

The more like-like the modeled procedure, the more confident the student felt about doing the skill. Observing the skill in the context of the clinical setting seemed to be the most helpful. In the following example the problem was not how to write and replace the tapes on this infant's tracheostomy tube, but how to do it in the

content of a very active infant whose physical condition would be jeopardized if the tube came out accidentally.

Student is in: Her trach [tracheostomy tube] ties are too loose. It slips out when I pick her up. EE: "Do you have some twill tape to put on?" Student: "I've never changed it before." EE shows her how KK ties to cut off, then begins cutting tape in preparation for attaching it to the tracheostomy tube. EE is not explaining what she is doing. EE: "What you do is take one side first and fix it before you do the other side. Now you gotta help so it doesn't come out." EE attaches new tapes. Student: "That's neat how you cut a hole. A good idea." EE doesn't know knots. Does it usually take two people to do this?" EE: "Yes, you should always have two. Never change trach tube without another person there in case something happens."

In this incident, the student observed a model that supplemented the model she had observed in class. This student was able, a few minutes later, to perform this skill on another patient with the staff nurse standing by as the second person. The demonstration model was an effective model for this student in this situation. In another clinical situation the student showed that she had learned some of the principles of patient restraint, but she neither did not copy the model completely, or she had observed an inadequate model. The instructor provided a demonstration model and also verbally pointed out why a certain component was an essential part of the skill.

The instructor has just pointed out to the student that the infant is restrained in an adequate manner. Instructor: "It's not a good idea to restrain her to the ECG pad." Instructor unres restraint. "The it down here or down here." Instructor ties places on bed frame. The cardiac monitor goes on. The instructor readjusts leads, then rearranges suction tubing so it is more convenient and doesn't get tangled with the cardiac monitor wires. Instructor: "Now restrain her like this." Positions patient and ties restraint to bed frame.

Rehearsing

The second step in the learning process for nursing students in this clinical setting was rehearsal. Rehearsal was a mental, and sometimes behavioral, process of repeating the sequence of steps that the student had encountered in the observing stage. Rehearsal was an important step in helping the students fix the information in their minds so that it was more easily retrieved in the actual doing step. Rehearsal was sometimes sketching the student did silently without involving another person in the process.

Student: I think about what I'm going to do. Basically I sort of see it in my mind.

Student: Frequently when caring for a patient, especially when doing some kind of care that you haven't done before, just a skill that you haven't done before. You go over it in your mind's eye and then you perform it.

Rehearsal could occur during the student-instructor interaction. The typical question and answer interactions could also teach students the value of mental rehearsal.

Instructor: What helps your learning of a skill?

Student: I hate to say it, but the professors quizzing you before you do something because it gets it in your mind. It gets you trained into thinking through all the steps before you go out and do it so you don't get in the middle and draw a blank. From then doing it to be enough my junior year, I do it automatically to myself my senior year.

Rehearsal also served the useful function of increasing the likelihood that the student would reproduce the procedure correctly in the actual doing.

Student: If you define the steps in a procedure then you have a chance to remember before you get involved. You have a chance to remember if you left something out.

Rehearsal took many different forms. In one form the students approached the instructor or a staff nurse and asked them to listen while the students verbally rehearsed what they were going to do. In addition to serving the purpose of fixing the steps in the students' mind, it was a safety check. The instructor or staff nurse could correct the students' actions before they involved a real patient.

Student: I'll sit there with someone, usually it's a nurse, and say "this is what I'm going to do" and explain it step by step to her and if I've done it right verbally, then I go ahead and do it.

Student: Usually the night before I read up on anything ~~new that~~ I knew that I'm going to have to do. But if it's something that just comes up on the floor then I try to find somebody who's already done it and say, "Okay, I've got all this together, I do this, this, this" and see what they think.

The student might rehearse in several different ways before she performed a procedure. In the following incident the student rehearsed independently with a textbook, rehearsed with a staff nurse, and finally rehearsed with the instructor.

Student: The patient had pulled his [nasogastric] tube out and we had to put it back down. So I read [with me down to Lippincott [nursing reference book]] and read up on it a little bit on there. And I checked with some of the nurses and talked to the clinical instructor and then I went in there and did it under their supervision. I really would rather do it myself like I did then watch, because I had seen it demonstrated before and it was a good chance to actually practice. (88/9)

Writing down the steps to a procedure was another form of rehearsal. If the student then reviewed the list immediately before doing the skill, she was using another form of rehearsal.

Student: We have a working care plan and I fill that out and I look up the pathophysiology and the problem and write it all out because writing it helps me remember it.

The student who practiced a procedure in the skills lab was also doing rehearsal. The added feature of this kind of rehearsal was the motor component of the procedure. The students actually rehearsed the required manipulation of equipment and supplies in a low stress environment.

Student: [in the skills lab] you're not working around a PROTECTOR that has the potential to evaluate you. You can ask all the dumb questions in the world. It's kind of just it is your mind. It's like "Well, okay, at least I've done it on the dummy." Most of it is getting the steps down.

Asking questions was sometimes a form of rehearsal especially when the student asked "should I do this?" rather than "what should I do?"

The student has medicines to give through a feeding tube.
Student to SG: "Is there one [she has several] syring(s) of medicine? They should go first? No, I know, I should listen first [check placement of tube]. How much [she] should I put in?" SG: "We usually put in 4 to 5 cc's." The student fills a syringe with air, inserted it into the feeding tube while listening to the student with the stethoscope. Student: "sounds like a little quark." SG nods yes. SG: "I always aspirate, try to get the air back. Just pull back to 4 or 5 cc's." Student aspirates. Student: "Now put the meds in?" SG: "Right." Student: "And it doesn't matter [which syringe goes in first]? SG shakes her head no. Student: "Then you put in five cc's of water?" SG nods yes. The student flushes the feeding tube with water and the SG leaves.

If the students did not have adequate rehearsal time, they did not retain the model in their memory. Students pointed to the large amounts of new information that they were expected to assimilate and noted that frequently there was not adequate time for rehearsal.

Student: When you're trying to learn it all at once for that week in clinical, then that makes learning any of it well. It's kind of like you get a tentative grasp on it and you just hang on to it for that day and that stuff is lost real easily.

Doing

Students were in total agreement that the most important step in the learning process was the actual doing. Without the actual doing the students would not remember how to do the skill nor would they feel that they knew how to do the skill regardless of how well they could describe it verbally. Doing was also an important part of looking good as a nurse. Each skill the student mastered increased her self-concept as nurse.

Student: Every little thing I do, even if it is
 trivial, builds my confidence.

Doing outside the context of the clinical environment was only rehearsal. The students might feel a little more comfortable, but they did not feel that they had mastered a skill until they had done it with a patient in the context of the clinical practice setting.

Student: It's a lot easier for me to learn by doing it. The skills lab doesn't help that much. It helps getting you familiar with the equipment, but it's just whenever you go into a patient's room it's a lot more stressed because it's real life and [in the skills lab] it's just kind of pretend.

Student: When I looked up the [central intravenous line] in the skills lab, I didn't do it taking me apart that was already there. We just saw how everything went together and it is different when you do it in real life--and it's different when the baby's crying and thinks you're going to do something to her.

The students found that the concrete feedback that comes from doing a skill was important for them to retain that skill. In some situations the doing, when the student was supervised, was a kind of motor rehearsal. The students rehearsed with someone there as a prompter in case they forget part of the model. Doing as rehearsal appeared to be more essential for some students. Other students did a

procedures once and were satisfied that they could reproduce it at a later date.

Student: I'd just as soon jump in and have someone watching me because--well you can watch someone doing something--I'd just as soon do as much as I can myself. It will take longer to do it with the person the first time if you've never done it before but to be the more I can actually be involved doing it the more it's going to stick in my mind. You know it's like watching--we watch these little movies on it--but there's no way that's going to stick in your mind until you've actually been exposed to it.

Evaluating

Evaluating was the step in which the students determined the adequacy of their learning. In the experience of the students in this study, this aspect of the learning of a skill was neglected by the instructors and staff.

Student: I asked [previous instructor], "you don't say anything. How do I know what's going on?" She said, "Well, if I don't say anything, you're doing all right."

In all of the student-instructor interactions that were observed, there was only one incident of concrete, positive feedback although many procedures were discussed or observed. There was one incident where a student had done a gastroscopy draining incorrectly; she was given concrete feedback including coaching while repeating the procedure. In addition, there were other examples of minor kinds of negative feedback. Because of the lack of verbal feedback, evaluation was largely an internal process based on the students' feelings of competence and their evaluation of largely non-verbal cues from the person doing the instruction or supervision. In skill performance, the student was primarily concerned with looking good as a horse. It

was only when the instructor was asking or asking them questions about the skill that the students pursued the goal of looking good as a student. He was told the students that they were safe. They learned to rely on their own evaluation.

Student: It's just a feeling in my heart that I feel complete and safe.

Student: [I know I'm doing well] if I were to do something that I've never done before and I did it right, I can just feel it if I do something right even if my teacher doesn't give me any [feedback]. Because a lot of times on the floor they don't give you any feedback. If I did something that I had never even tried before in my life.

In order to learn a new clinical skill the student first observed a model, rehearsed the skill in some way, then performed the skill as a patient. Finally the students evaluated their performance of the skill in order to identify the need to observe again or modify the doing the next time they performed the skill.

Coaching

Coaching was a learning experience that seemed to combine observing, rehearsing, and doing in a repetitive sequence. The person providing the instruction presented a verbal model saying, "now do this." The student rehearsed this step by actually doing it with a patient under close supervision. This cycle of observing a verbal model and rehearsing by doing was repeated for each step of the procedure. This approach to learning was especially useful for learning very complicated skills and in clinical situations where the student might not have another opportunity to do the skill in the near future. The student was able to compress the usual learning process

into a brief time frame, and the patient was protected by the presence and close supervision of the instructor or staff nurse. In the coaching experience the student usually did not feel evaluated. The person doing the coaching assumed that the student did not know and needed to be instructed.

Student: The most helpful thing is if the nurse will CUT the through it so that I can do it myself, but I know that she's not going to let me make a mistake.

The student is giving an oral medication. Instructor: Let me show you the easiest way to do it. Just support with this hand. Then you can control her head with your other hand.

Coaching to Manage Student Stress

The students had all had instruction on how to give injections to children and most of them had an opportunity during the junior year to actually give an injection to an infant or small child. However, this remained a high stress task for the student. Coaching was one way for the instructor or staff nurse to help the students manage their stress as well as to insure the safety of the patient.

Student is about to give an injection. Instructor: "Now when you give the shot, where are you going to give it?" Student: Right here on one of the legs. She has band-aids over the arms." Instructor: "Take them off and feel them and tell me where you want to give it. You'll probably feel some knots. You need to be listening. What you need to do is go to the muscle and lateral."

Instructor is showing her where on the thigh is the appropriate site for the injection. Instructor: "When you give it, if you grab the knee, do it with your left hand so you're free to give the injection." Student starts to prep site with alcohol. Instructor: "Don't rub it. Friction helps more than the alcohol." Student starts to remove needle cover with her teeth. Instructor: "That's not a good way. You run big a risk of contamination." The student releases her grasp on the infant's leg and uses both hands to remove the needle.

cover. [Instructor] "Hold that leg immobile now."
Student gives injection. 104,01

Coaching for Unanticipated Learning Opportunities

Coaching was frequently used to help when the students needed or wanted to perform procedures that they had not anticipated and therefore had not prepared to do. The student in the following situation unexpectedly had the opportunity to insert a nasogastric tube. She had practiced on the manikin in the skills lab at some time in the past. Students reported that they experienced more stress during any kind of intrusive procedure and therefore frequently needed coaching the first time they tried it on a real patient.

SS: "You going to put the [nasogastric tube] in now?"
Student: "If you'll help me, I haven't seen [my
Instructor] this morning." SS: "Even though she's on
isolation, when you're putting in a [nasogastric tube]
it's impossible to wear gloves so you'll just have to wash
your hands really well." SS shows her how to prep the
skin around the patient's nose and measure the tube.
Student: "Does it matter which nostril?" SS: "Use your
SNG. We try to alternate sides." Student starts trying
to insert the tube--is pushing it in fast and the patient
is flailing around. SS: "You kind of have to let her
rest a minute and see if she will swallow." Student: "I
don't resistance." SS: "Let me feel it a minute."
Student: "Now it's going down." The student puts the tube
all the way in and the SS shows her how to tape it in
place. SS: "That's enough for right now. Now check for
placement." The student injects air and listens with a
stethoscope. After corrects stomach contents. Student:
"Do you want to listen?" SS: "I'm sure you're in the
right place."

Coaching was frequently the strategy of choice when the procedure was
a non-recurring one. Students would say that they wanted a
demonstration first but, when asked by the researcher, "would it make
any difference if it were a one time procedure that you wouldn't get

to an expert", the students invariably chose coaching—that they frequently referred to as "talking me through a procedure".

Coaching for Complex Procedures

Coaching was also a useful learning technique when the student needed to learn a procedure with many steps. In the day described below the student a assigned patient needed to have her intravenous fluid bag and tubing changed. This was an unusual opportunity for students in this clinical area, because the IV tubing was routinely changed by the nurses on the night shift. The procedure had many steps, and this instructor coached the student through the procedure. She did not question the student. The instructor assumed that the student needed assistance and provided it in a manner that did not appear to be evaluative.

Instructor and student came into room with an IV bag and tubing that have already been connected. Instructor: "Now we need to fix this so it will run with all of these things." Instructor disengages tubing from access and reconnects it to gravity flow. "There are different ways to do it but the way I do it is just to push it so no air can get in and just put it to gravity." Instructor moves bag to IV stand at other end of crib and checks that IV is dripping. Instructor: "We need another one of these—in treatment room." Student left room and returned with a cassette. Instructor: "To figure out sequence look at the side." Turned 180° around. "They tell you the basic sequence. Go ahead and pull that out. Instructor moves break cart between them. "You can just throw stuff in here as you need to. Look at the screen. At the back. It won't fix unless it's at the same angle. Push purge until it's pointing that direction. Worry about getting the top too secure and then get the bottom. Student inserts the cassette. Instructor: "Just twist that in. Enough so it's secure. If you try to get it too tight you can get a hole in it and then you have to start all over. Purge as you go. To purge take that off. Don't concentrate it. The next is put it on again. Hold that over the ventouse. You have to hold the purge button with your finger." The

student is following instructions. The instructor continued in this same fashion through the rather complicated task of doing a complete tubing change.

The student was able to repeat this procedure the following day without any assistance from a person. She used the existing setup as a model to stimulate her recall of the steps in the procedure.

Student: I did it on my own the next day. I had to really view and think it through. I mean, I did it slowly and I had to really think about it. I had to follow it, to look at it before I put it together. I didn't remember from that one time. I wouldn't have been able to just go out it together someplace else and then look it up. I had to follow what was already there—but I did it on my own that day.

In the following illustration of coaching, the staff nurse remained calm and supportive throughout the procedure. Students have identified this calm, coaching approach with increased learning.

The patient needs a new [asymptotic] tube. N: "Okay, do you want to do it? Have you ever done one before?" Student: "No, but I'd like to do it if you'll talk me through it." N: "Let's talk about it first then. Tell me what you're going to do." Student: "First measure from ear to nose to stomach and tape." N: "There's marks on the tube but you can use tape if you want." Student: "Then lubricate it and then put it in. Which nostril?" Turns to patient. "Oh, yes, put it in the other one [opposite the last tube]. Is an adult you get them to swallow?" N: "Go between coughing, we'll swallow then." Student: "Do I do it fast?" N: "I do." Student: "To cough?" N: "Yes. She's had to cough in STRONG what about positioning?" N: "I'll hold her for you." Student: "You bend her head forward." N: "Don't need to use extreme flexion in babies like in adults." Student: "Is this a sterile procedure?" N: "Yeah—it's not dirty but not sterile because you're going to the stomach. You might want to clean up the nostril and put a Q-tip in it. Suck up everything first because you'll need it all at once." Student: "What do I do with the Q-tip?" N: "I'd leave it in the bottle. It dries out real fast." Student: measures tube. N: "No, go from here to here to here." Student: "How far do you [lubricate] tube?" N: "Just a little, that's fine." Student: inserts tube. COUGH starts coughing. N: "She'll swallow in just a second. Okay, you got it. Check it quick." Student: injects air. side head. N:

"I heard it. And your hands are real quiet." Student points his wrist towards Student. "How do you use these latent-strips?" He: "You don't know how to do that at all!" Demonstrated how to get strips off backing and how to place first tape. He: "Now it's good and anchored, so take your second one. That's it. You're done."

Coaching as rehearsal

In coaching, the motor performance, the doing, seemed to be a kind of rehearsal mechanism. It was observing, rehearsing, doing, and feedback so intertwined that it was difficult to distinguish the parts. Coaching seemed to be more effective for some students than others. Some students seemed to need the doing to be able to retain a model. They did not benefit as much from visual or verbal symbols. These students reported that they would rather have coaching than a demonstration.

Student: If I actually have it in my hands then I have to say "well, this is what I'm doing" and I seem to be able to keep up with it better. Plus I find that I learn or remember a lot better if I make a mistake while I'm doing it. A lot of times when I was doing something... [the instructor] would let me do it, ... she would see me make a mistake, she would tell me and I'm like she's busting through it all. I remember next time that's what she got me for, so I have to remember not to do it next time. So I really prefer for them to be there to tell me what to do and let me make my mistakes so that I can learn from them.

Other students found coaching to be confusing for them unless they had already seen a demonstration. These students were still helped up coaching, but they needed the big picture of the entire model first.

Student: I guess it's always best for me to watch it first then to just go ahead and do it. Because [during coaching] you don't know what you're doing and it doesn't make as much sense. You can't see it flow. If I stand back and see how everything works, it makes it a lot

easier than if I'm doing it first myself and not knowing the right way until someone tells me "do this, do this."

Student I think it's better to see it done first than to do it. Because talking through it gets confusing as far as "do you want me to coach it?" You're in the sterile places and you're in the sterile field and they're not. They can't get over to show you. I think it's better if it's demonstrated first.

If the procedure was one that the students would have many opportunities to try they described an ideal learning sequence of demonstration, verbal or mental rehearsal, coaching, and independent doing.

Student I would read on how to do and if it were possible I would go to the skills lab and practice. And then when it came time to do it, I would ask that somebody be there and talk me through it, or a lot of times they'll say, "you tell me what you're going to do and then I'll tell you if that's right or not, or if you're skipping anything, or if there's a better way to do it."

Student The best thing for me is to do [the procedure] with [the instructor] once-- go over it with her before hand and then go in and try to do it myself, and then the next night go do it myself. Then I've got it. Talking it through and then doing it.

Student If they'll talk through it and tell me, talk me through it. It helps to do it on a dummy first, just to get a feeling of the equipment. Like I had put an NG tube down a dummy but it's not quite the same thing. It helps if I learn about the procedure either by book or by somebody talking me about it--how to do it step by step. Then I do it up in the skills lab and then on a person. And if somebody--when I'm doing it on the person--it really helps me if somebody tells me "now do this", and the next time I can do it myself.

The sequence of steps in the learning process experienced by the study group of nursing students was consistent with the components of observational learning proposed by Bandura (1977) in social learning theory. According to Bandura there are four component processes in observation learning: attentional, rehearsal, motor reproduction,

and motivational processes. Observing was part of the attentional process as were the aspects of the nursing student perspective that led the learner to observe a particular model. The effects of the nursing student perspective on the learning process will be described in the next section of this chapter. Mental and behavioral rehearsal were part of the retentional process. Doing, evaluating, and refining skill performance based on evaluation were included in the motor reproduction processes. The final component in Bandura's observational learning was the motivational process. There were aspects within the nursing student perspective that matched the motivational process. Bandura did not use a term comparable to coaching although, because coaching was simply a repetitive cycle of the observing, rehearsing, and doing steps, it was consistent with the attentional, retentional, and motor reproduction components of Bandura's observational learning.

Effect of the Nursing Student Perspective on Observational Learning

The nursing student perspective described in Chapter Four had an effect on each component of the learning process. The component the most affected by this perspective was the entry point to the learning sequence.

Selecting a Model to Observe

The students frequently had considerable freedom to choose the person or other model that they would approach for help in learning

a new skill. The model that they chose was based on the availability of that model and the attractiveness of that person or resource as a model for a particular skill. The students had a large number of potential models readily available to them. They had written models from course materials, verbal models from lectures, clinical instructors and staff nurses, and they had demonstration models from models from instructors, staff nurses, peers, and nursing assistants. The students were necessarily selective in their attention. A major factor in the students' decisions to attend to a particular model was the safety of the patient.

Instructor: Are there any questions you shouldn't ask?

NSP Instructor:

Student: I was always hesitant about [asking] about some things that I thought I should have a better understanding of. But if it got to a point where it was going to affect some procedure that I was going to do then I would go ahead and ask even though I might feel degraded.

The student was more likely to attend to models when she was going to see clear results. This was an effect of the looking good as a nurse goal. A student caring for an infant with multiple problems who was difficult to care for physically said that her instructor's questions about why the child hadn't gone home yet were not justified, because they didn't have anything to do with the immediate care. This student could not see beyond the immediate situation and appeared to attend only to models that helped her meet the patient's obvious physical needs.

Because the students had to deal with the immediate if they were to do something positive for the patients, they had to turn to the models that were most available to them. Frequently this model was not the instructor. The instructor was responsible for 12 to 18

students of her location, so she was often unavailable when the student wanted to learn something. Taking the time to track down the instructor took time away from the patient, and the students resented the wasted time.

Student: I found that because she wasn't around a lot that if I needed instruction and if I needed information she was not the one I would go to because I didn't want to have to hunt her down. And the nurses and the doctors were more easily available.

Student: Using the instructor would probably be best in that environment. Part of it is because she's an RN. There's so she won't be there at the time so this-way it would be more constructive to ask the aide or the nurse in charge of that patient.

If the student saw a staff nurse or instructor doing something positive for a patient, the student was more likely to choose to observe that person doing a nursing skill that the student wanted to learn.

Student: Seeing a top notch nurse on the floor work with a patient is really a wonderful learning experience. Seeing how they relate and how they do skills. There's one nurse on [elder pads unit] that is a real role model. I learned so much just by watching her interact with patients. It was really helpful.

The students' level of stress in a clinical situation affected their choice of models. When students were feeling very stressed, they perceived that their usefulness to patients was decreased. Stress interfered with their goal of helping patients. A large majority of the students interviewed experienced a great deal of stress in their encounters with instructors. This stress was totally related to the instructor's evaluative function.

Student: The professors tend to make us more nervous. So that I always end up kind of messing up. . . but if I had done it with the staff nurse or by myself I would have done it to perfection.

Student: If I think that I'm going to bring dire consequences upon myself if I do something wrong that produces a lot of stress and I tend not to do as well.

The students, in pursuing their goal of looking good as a student, wanted to impress the instructor. This often required not telling her that they needed help. Asking the instructor for help was a threat to the goal of looking good as a student and, because of the increased stress level, a threat to the goal of helping the patient. Some students were so stressed in their encounters with their instructors that it affected the quality of care that they were able to give their patients for the rest of the day. This frequently led to decreased use of the instructor as a model to observe.

Student: How can you learn from somebody that you're afraid they're going to bite your head off. And you're afraid that you're going to do something wrong, so you tend not to do as much.

Student: It's usually easier for me to learn from nurses than to learn from teachers because I'm so scared because they ask questions all the time, and I'm afraid I'm going to say the wrong thing.

Student: I knew I kind of avoid the teachers because I didn't want to get caught not knowing something. I go to the nurses more because I know I get the same information from them that I get from my teacher, but it wasn't as stressful. I usually learn better that way.

In situations where the students perceived that not using the instructor as a model would lead to harming the patient, they would ask the instructor. Doing so had had priority in decisions about which model to observe.

Student: I went the first week to have [the instructor] tell me, show me how to do an adapted bed, to change one, because I had never done that. I never had anyone that couldn't get out of bed last year, and this was a cancer patient that was in a lot of pain, and I didn't want to feel dropped with it. I was a little embarrassed because I was senior level, second semester, but then I thought

about it. "Okay, what is going to come first, my embarrassment or is that patient's comfort going to come first?" So I went and found [the instructor] and she said "I'm glad you came to get me". So some of it depends on the attitude of the instructor because of what I've heard, if I'd have gone to some other instructor and said that, they would have just looked at me and said "you should know how to do that, and I'm not going to show you how to do it."

Some instructors used instructional approaches and attitudes that encouraged students to use them as models.

The student was describing a teacher whose coaching was helpful for learning. She'd very unobtrusively say "why don't you put the gloves on next so you don't contaminate everything." She would just mention "do this next." Instead of saying "you're doing it wrong. Think." Because then you think, "oh, no, what have I done?" She didn't come down on you every time you made a mistake. She would just correct you and watch you the next time.

In the brief pediatric clinical experience, the students' response to the instructor appeared to be based more on their experiences with other instructors than on their experiences in pediatrics. Some students seem to be able to control the affect their efforts to look good as a student had on their choice of the instructor as a coach.

Student: I made a real decision this year not to let my instructor make me nervous and because of that have done extremely much better than I have in the past.

The students' goal to look good as a nurse attracted them to models that increased their sense of competence.

Student: [The staff nurse] helped me a lot in my learning because she gave me confidence and said, "okay, you know what you're doing. Go out and go for it." It made me feel better and I learned more around her.

The students' perception of the role of instructor and staff nurse led them to expect one or the other to be the correct model. The students were divided in their perception of who was the best

qualified to serve as a model for clinical skills. In response to a question from the researcher about who was the best person to ask for help when the student did a new procedure one student replied:

The instructor. If you can find the instructor and the instructor has the time to do it right then, that's the best procedure because then you're learning--or I feel like I'm learning--that I can say, "yes, this is the right way to do it", because I have learned from the other nursing staff ways to do things that the instructor came by and pointed out, "notice this", and you say, "yeah, you're right, that's not the best way to do it." The best person is definitely the instructor and second, of course, the nursing staff.

Another student responded:

Student: I'd rather go to somebody who's used to doing that stuff [other than the instructor] and ask them.

Resolving Conflicts between Models

The effect of the nursing student perspective became even more apparent when the ways students resolved conflicts between two models of the same procedure was examined. One of the consequences of learning in this kind of complex context was that many differing models were available to the student. Because the instructor was not constantly with the student, the student independently made many of the decisions about which model to observe. The students made these decisions in both the ways that they prepared for the clinical experience and in the people they approached for help in the clinical setting. The students were frequently frustrated by a discrepancy between the models they had observed.

Student: The one thing that always frustrated me is every OTHER situation is this discrepancy between what we're taught and what the nurses really do.

Student: So many people do so many things in different ways and that's not good for learning in a way.

During one observation period, a student changed a postoperative gown dressing without any assistance. Her instructor had given her written guidelines but, when the student removed the old dressing, she discovered that it was not applied in the manner described in the guidelines. The old dressing served as a visual model for this student, and she chose to copy that model rather than the written model provided by her instructor when she replaced the dressing. Later her instructor questioned her about the procedure she had followed, reprimanded her for not following the guidelines, and helped her reapply the dressing. The instructor emphasized that there was a right way to do skills that she wanted students to learn.

Instructor: Next time you do something how get someone to help you. If you are giving meds or doing sterile treatments I don't want you to do it unless an RN or I am with you. I know it's frustrating for you. I'm not putting down the staff but there are certain things I want you to learn a certain way. A lot of nurses take shortcuts and I want you to learn it the right way now.

The students' decisions about which model was right were based on their goals. When uncertain about the correctness of a modeled behavior, the students asked themselves, "could it harm the patient?" If the answer to that question was no, then the students' looking good goals came into action. If the instructor was going to be watching or was likely to check, the student would follow the model approved by the instructor or the one that the student could cite from a textbook. If the instructor was not around, the student might follow the pattern modeled by the staff nurse. This was part of the pattern of looking good as a nurse. The staff nurse represented what the student would

become and the student respected her experience. Since part of looking good as a nurse was being accepted by the staff, the student would frequently try the skill the way the staff nurse modeled it.

When the student was faced with a situation where the instructor was not immediately available, there was a staff nurse who had consented to help the student, and the student saw a discrepancy between what was modeled by the staff nurse and what she had learned in class or from the instructor, the student had to make an immediate choice. Frequently in nursing education there is no time lapse between observing a model and doing a procedure. The skill was modeled because the student needed to use it immediately. Often there was no time to think about it, or look it up, or talk it over with someone. Most students did not have the confidence to challenge the staff nurse.

Student: [The problem] was too serious to handle [the way the staff nurse told us to do]. I should have known that, but I'm not real confident yet, so if the nurse who's been doing it for years tells this is how to do it, . . . I'm not inclined to argue with her. . . but I should be. I need to learn how to do that.

One strategy students employed to avoid a personal challenge to the staff nurse was to say, "My instructor won't let us do it this way." This strategy assigned the blame for the challenge to the instructor. The student was implying by this strategy that she would like to do it the way the staff nurse modeled but that would get her into trouble with her instructor. She hoped the staff nurse would be sympathetic to this student dilemma. One student cited charting medications before they were given as an example of a model that she

had observed that conflicted with the model her instructor had presented.

Student: Things like that are simple enough. We just say "well, my instructor says we have to do it up this is what I'm going to do." But some things that I don't have real good information on and there's nobody there to ask except the nurse on the floor and then we get the wrong information.

When questioned about the criteria that they used for making a decision about which model to follow when there was a discrepancy, the students reported that they first looked at the seriousness of the discrepancy. Would copying the new model have the potential to harm the patient? If the students' assessment of the model indicated that this procedure would not harm the patient, the students' perceptions of the staff nurse became the major deciding factor.

Interviewer: What do you do when there is a discrepancy?
Student: It depends on the seriousness of the situation. If it's something I consider very serious I usually try to find my instructor and ask about it. If it's something that's not quite so serious I'm inclined to go along with the way they've been doing it. I'm not really the primary caretaker so we wait to go in there and screw up their system and do things differently.

Student: Sometimes I end up going the way the nurse says. Because after she explained it to me, then I feel like maybe since she's in the situation, she's been there with the patient, that's the best way and the quickest way to do it.

Student: Another example was a postop little girl last week. At reports I asked when they were doing coughing and turning. And the nurse really awakened from the anesthesia but it had been 12 hours—she was really up. This older, very experienced nurse just kind of scoffed at me and said, "let her sleep, she needs her sleep." And I can remember one of my instructors saying if the postop patient has sleep through the night they haven't had good nursing care. So I compromised on that one because she was in good shape.

When the choice was between following a conflicting model or not doing the procedure, the students expressed a feeling of frustration about the lost learning opportunity. This choice was also a threat to learning posed as a nurse because the students were expecting something that the staff nurse wanted them to do.

Student: I remember when they were telling us to never give a med that somebody else drew up. I find nurses who say, "Are you giving meds today? I already drew this up, here it is. Go ahead and give it." I feel like I'm kind of in a situation where I want to go ahead and give it and learn the skill, but I have to say "no, I didn't see you do it" or "I don't feel comfortable doing it because you drew it up first or because I didn't see you do it." I feel like they think I just don't want to do it and don't want to be helpful or whatever.

The instructors had developed some ground rules about how some procedures were to be done but, because of the unpredictable nature of the clinical area, it was impossible to list all possibilities without telling the student, "you must find me to sign-off on you before you do anything new." This approach would severely limit the students' opportunity to learn new skills because of the instructor-student ratio.

Believing a Rule of Learning

The nursing student perspective not only influenced what the students chose to use as a model but also affected the type of model they wanted to observe. The more risk to the patient that a procedure involved the more likely the student would want an actual demonstration, rehearsal, and coaching.

Student: I observe the first time usually, unless it's something simple—dressing changes and things like that—I have someone just talk me through it and I'll do it. ?"

it's something that is either complex or it's uncomfortable with, something I was a little uncomfortable with, something through the track, so I observed first what's going on there.

Researcher: Can you tell me what about it made you uncomfortable?

Student: Just that it was invasive and that it was going into this person's body and imagining what it would feel like for myself to have someone doing that to me--very uncomfortable. Whereas something like a dressing change that is not as invasive or uncomfortable to the patient there's more leniency there. There's just sterile technique and that's all right.

Effects on Role of Student

Event rehearsal was common because it was one of the strategies students could use to help protect the patient. Students repeatedly told the researcher, "I want to do it with someone there to tell me if I do something wrong and to protect the patient." The same aspects of the perspective that affected the students' choice of models to observe also affected the rehearsal process. If the students felt confident that they knew the steps in a procedure they might choose to rehearse with the instructor since that presented an opportunity to look good as a student.

Student: I don't like to ask the instructor anything. I like to be able to tell her things. "I know how to do this because . . . I can do this. . ."

Effects on Safety

Safety was discussed until pins were sure. Students counted on staff and instructor to ensure patients' safety. Safety was not as much affected by the nursing student perspective as it was the culmination of all the goals in the perspective. When a student

performed a skill well she had protected the patient from harm, helped the patient, used something from theory in clinical practice, learned a clinical skill, looked good as a student, and looked good as a nurse. The doing was both the end point of the learning process and the end point of each of the goals.

Motivating Factors in the Nursing Student Perspectives

The choices the students made throughout the learning process were affected by the nursing student perspectives. These choices implied that the student had already decided to observe and to use what they had observed. A skill that had been learned was not necessarily used unless there was sufficient motivation for the student to perform what she had learned. Each of the six goals were also motivating forces that prompted the students to want to learn and to use what they had learned.

Looking good as a student was a motivating factor. The student was more likely to have investigated a model if observing a model would help them look good as a student. Instructor evaluation and grades were motivating factors.

Student: I'm the kind of person that tends to spend pressure to perform and if [the instructors] don't expect a lot out of me then I don't expect a lot out of me. I found that [an instructor] really expects a lot out of you and I found myself doing better for her than I have done for other instructors. So I think having an instructor whose expectations are high really helps. (20,11)

Looking good as a nurse and helping the patient were also motivating forces. This student was motivated by her goals to observe appropriate models and then to use the skill that she had observed.

Student: I like to teach. [I'll ask the patient or family], "Is there anything you need to know before I go home tonight so I can read up on it tonight and I can talk?" And a lot of times I'll tell them "I may not know it, but I can find a person who will answer your question. A lot of people are real busy but I am your nursing student. You have an extra person, that you're really my patient. I have extra time so that if there is anything you need use me."

The strongest motivating factor was again the fear of harming a patient. The patient would be harmed if the students did not observe the appropriate models and if they did not use what they had observed and learned.

Student: One thing that motivates me is, "What if? What if this happened to your patient? Are you competent? Do you really know what you're doing? Are you going to be able to handle it without freaking out?" That motivates me to learn.

The nursing student perspective affected the students' entry into the learning process by factors that provided motivation. It also affected each step in the learning sequence. Thus the ways the students defined their experience also shaped their experience. The process of learning and the effects of the nursing student perspective on that process within the study group of nursing students is consistent with the social learning theory proposed by Bandura and reflects the social interactional nature of meaning identified with symbolic interactionism.

CHAPTER SIX

CONCLUSIONS AND IMPLICATIONS

Summary

The purpose of this study was to explore and describe nursing students' experience of learning within the context of one clinical practice setting where the students learned to provide nursing care for acutely ill infants. Researchers who have investigated clinical learning in nursing have tended to focus on outcome variables (Oyers, Dickelmann, & Thompson, 1978; Kirchhoff & Wolgemut, 1976; Koch, 1976; Mackie, 1973; Pearson, 1978; Roberts & Thurston, 1984; Schlechtman, Holzman, & Farness, 1984) or on learner characteristics (Oaker, 1976; Rubenstein & Parsons, 1972; Entwistle, Van Rossum, Schaffel, & Crowell, 1984; Kadman & Allen, 1974; Kaylor & French, 1975; Williams, 1971). These studies have isolated single variables or groups of variables and measured relationships between sets of variables or the outcome effects of treatment variables. In this study, learning was approached as a process that takes place in a complex social context and that is affected by the interaction between the students and all of the contextual variables. The significant variables emerged in the process of data analysis; they were not identified prior to data collection.

In order to identify the components of the nursing students' experience of learning, the researcher observed in one clinical

practice setting for approximately 35 hours over the semester. In addition, the researcher interviewed 30 of the disordered students during the six-month data collection period. Observations and interviews were focused on students' verbal messages about learning, their clinical practice related behavior, and their use of learning resources. These kinds of data were used as indicators of the students' experience of learning in a clinical setting.

The collected data, in the form of expanded field notes and interview transcripts, were analyzed using the procedures outlined by Spradley (1979, 1990). First, the data were organized into domains or categories based on similarities. Domains that were useful in understanding the data included kinds of Student-Instructor Interactions, Reasons for Student-Instructor Interactions, Characteristics of New Skill Acquisition, Kinds of Student Problems, Kinds of Things that Help Learning, Ways Students Learn New Skills, Ways to Improve Chances of Looking Good to the Instructor, Ways to Teach, and Ways to Get Help. Data were drawn from these domains to construct taxonomies which provided the frameworks for the nursing student perspective and the process of learning a clinical skill.

The Nursing Student Perspective

Perspective was defined as a shared understanding of a given environment or situation which guides a person's behavior in that situation. The nursing students in this study used the following perspective to make decisions about their actions in the clinical setting:

1. The students' self-defined goals were the major framework of the perspective. The nursing students formulated six goals for clinical practice time: (a) to cause no harm to a patient, (b) to help patients, (c) to integrate theory-based knowledge from lectures and reading into clinical practice, (d) to learn nursing clinical practice skills, (e) to look good as a student, and (f) to look good as a nurse.

2. Within the framework of these goals, the students also defined student, instructor, and staff nurse roles. The students defined two roles for themselves--that of student and that of nurse. These two roles were not always compatible. A student's response to a problematic situation in the clinical area was determined by which role the student had assumed in that situation. Instructor roles, as defined by the students, included evaluation, teaching, protecting the patient, supporting the student, and partial role modeling. Evaluation was the predominant instructor role defined by the students. Students defined staff nurse roles as teaching, supporting the student, protecting the patient, and being a partial role model.

Learning in a Clinical Setting

The process of learning a clinical skill was composed of four steps: observing, rehearsing, doing, and evaluating. This process could take many forms. A special form of this learning process was identified in which the steps were interrelated in a cyclic process described as coaching. Coaching was a frequently experienced process for students in this clinical practice setting.

Nursing Student Perspective and the Learning Process

The nursing student perspective affects this learning process by determining the student's choice of models to observe, the choice of which models they would imitate, the forms of rehearsal the students employed, and student assessment of readiness to do a skill without supervision. The nursing student perspective also provided the motivation for the students to observe and to use what they had observed in their clinical practice.

Relationship of Findings to Theory

Symbolic Interactionism

The nursing student perspective, as defined in this study, is consistent with the premises of symbolic interactionism. Symbolic interactionism is a sociological theory in which meaning is an outcome of social interaction. Meanings are "social products, creations that are formed in and through the defining activities of people as they interact" (Flower, 1968, p. 8).

The first premise [of symbolic interactionism] is that human beings act toward things on the basis of the meanings that the things have for them. Such things include everything that the human being may refer to in his world. . . . The second premise is that the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows. The third premise is that these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters. (Flower, 1968, p. 21)

The social context of the clinical setting and the interactions that occurred there among students, instructors, patients, and staff

were the basis for the meanings the students assigned to the learning process and to the roles each individual played in this clinical setting. The students' definition of a learning environment changed as they left the classroom setting and entered a clinical practice setting. There was a constant interplay between defining the situation (assigning meaning to people, things, and events) and responding to that situation. The nursing student perspective is a summary of the meanings that the students derived from their interaction in this social context.

The usefulness of the tenets of symbolic interactionism in this study point to the potential use of this theoretical framework in further research on learning in a clinical setting. Because symbolic interactionism is a theory about social contexts and interactions it is suitable for use as a research perspective in studies that are conducted in a social context. Studies of nursing student learning in laboratory settings, such as a clinical skills laboratory, will show how students learn in laboratory settings rather than how students learn in actual clinical settings. The meanings assigned by the students to people, things, and events in these two settings will be different because the social contexts are different. Symbolic interactionism is a theory that can best be used in field rather than laboratory research.

Social Learning Theory

The process of learning clinical skills identified in this study is consistent with the process of observational learning described by

Bandura (1977) in his theory of social learning. Observational learning has four component processes--attentional, retentional, motor reproduction, and motivational. The components of the process of learning a clinical skill defined in this study can be identified with these components of observational learning from social learning theory. The four components of the learning process in this study were observing, rehearsing, doing, and evaluating.

The first step, observing, is part of a Bandura's attentional process. According to social learning theory, learners are selective in their attention to models. The counterparts in this study for this selective attention are those components of the nursing student perspective that determined the students' choice of models to observe. Bandura attributes these choices to the attractiveness and availability of the model.

The rehearsal process consists of symbolic coding (a cognitive process) and rehearsal. Rehearsal, in this study, seemed to imply mental coding in that there was mental recall of previously observed behaviors. While the data collected in this study were not suited to demonstrating the existence of this coding process, there was nothing in the data to suggest that coding did not exist and such evidence to suggest that coding is a necessary antecedent to rehearsal.

The third component process in Bandura's observational learning is motor reproduction. The equivalent step in this study was identified as doing. In this study, evaluation was identified as a separate step. Bandura does not identify evaluation as a distinct step, but describes the feedback a learner receives from the motor

reproduction component as a part of the process of correcting and refining a skill in a subsequent motor reproduction.

The fourth component of Bandura's observational learning is the motivational process. This is the process by which the learner chooses to use what he has learned in the observational learning process. This is most closely identifiable in this study as the ways that students managed conflicts between two models of the same skill. These motivating factors were part of the nursing student perspective.

The components of observational learning are a part of Bandura's larger social learning theory. Most studies of this theory have been in experimental laboratory situations where the contextual variables could be controlled. The explanatory power of the observational learning portion of social learning theory for the findings of this naturalistic study of learning suggests the usefulness of this theory for further context-oriented studies. Social learning theory can provide a theoretical perspective for research in nursing education as well as research on learning in other educational environments.

Relationship to Previous Studies

Socialization studies in nursing have been focused on either the process of acquiring the values and attitudes of the profession or on the outcomes of the socialization process (Brown, Swift, & Sherman, 1974; Davis & Glass, 1964, 1970; Glabe, 1977; Glass & Whitaker, 1968; Ostrick, 1971; Simpson, 1967; Warner & Jones, 1971). This study adds to this research by defining the ways in which the students'

ideas about the clinical environment affected not only their attitudes and values but the actual learning process itself. For example, the do no harm goal is a desirable outcome of a nursing education program, but this study revealed that this attitude toward nursing had value beyond that of an outcome variable. This attitude had a major effect on the ways in which students experienced the learning process. Students were not passive recipients of the educational program, and their responses to that program were interactively determined.

Researchers of teaching and learning in nursing have examined variables in the instructional approach (Hyman, Ciolekiewicz, & Thompson, 1971; Kinoshita & Hollamer, 1979; Koch, 1979; Mackie, 1973; Pearson, 1979; Roberts & Thurston, 1984; Schleuterman, Hollamer, & Farnard, 1984), teacher characteristics (Barham, 1960; Brown, 1981; Dale & Reiser, 1978; Jacobson, 1969; Kame & Schwab, 1982; Lytton, 1985; O'Don & Person, 1979; Ryan, 1979; Stafford, 1979), and student characteristics (Baker, 1938; Bakkenkamp & Persons, 1978; Bittner, Van Riper, Scheffel, & Crowell, 1984; Anderson & Allen, 1974; Butler & French, 1975; Williams, 1973) primarily in terms of outcome criteria or findings of opinion surveys. The few studies of the teaching-learning process have been focused on the instructor doing the teaching rather than on the student doing the learning (Carr, 1983; Infante, 1938; Kamen, 1980; Pugh, 1981). This study contributes an understanding of the process students experience in the clinical education setting. A question yet to be answered is "how do the important variables identified in previous studies contribute to the development of the nursing student perspective".

In previous studies, learner characteristics, instructor characteristics, or instructional designs were examined for their relationship to educational outcomes rather than the effects of these variables on the learning process. This study suggests that the effects of changing contextual variables on the learning process will be noticed through changes in the nursing student perspective rather than by actual changes in the learning process. Spending learning time from clinical evaluation time might change the student perspective of the instructor's role and thereby influence the students' choice of the instructor as model.

The findings of this study also suggest that changing a variable after the nursing student perspective is formed may not have an immediate effect on the students' actions. The students in this study responded to new situations out of a perspective that was already formed. Their responses to the potentially clinical instructors appeared to be based on the meanings they had assigned to previous instructors and to previous student-instructor interactions. Even while the students acknowledged that each instructor was different, they reported difficulty in changing their behavior with a new instructor.

Use of Findings to Research Community

The findings of this study are of value to researchers in three ways. This study identifies context-situated variables that can be studied in further research. It raises questions for further

research, and it demonstrates the use of a methodology that has been infrequently used in nursing education research.

First, the description of the nursing student perspective and its effect on the process of learning provides a detailed account of the variables in student learning in a particular clinical setting. Variables such as students' previous experience of instructors, degree of patient risk involved in clinical settings, amount and type of feedback, and the students' sense of competence had an influence on the development and use of the perspective. Some of these variables have been studied by previous researchers. Feedback has been identified as an important variable by both students and instructors (Zilles & Farson, 1976). Findings of this study indicate that these variables interacted in the social context of the clinical practice setting to affect how nursing students defined and responded to one pediatric clinical practice setting. Continuing research needs to be conducted on each of these variables with attention to the interactional nature of the experience of learning in a clinical setting. The failure of researchers to relate individual variables to the total context in which clinical learning occurs may lead nursing educators to make poor decisions about curricula and instructional approaches.

The second area of value in this study for researchers is the many questions that are suggested by these findings. The questions relate to contextual variables that seemed to have an effect on the development of the nursing student perspective. The perspective presented in this study was already operational in the students' clinical practice experiences. A recurrent question was "how did this

perspective develop? What parts of the perspective existed because of entering student characteristics and previous learning experiences? What factors in the first clinical course contributed to the emergence of this perspective? Were early experiences in clinical practice setting the important factor? How easily could the perspective be altered by the ongoing experience of clinical practice courses?

Another question is raised by the students' definition of themselves as nurses and the looking good as a nurse goal. The student's sense of self as nurse seemed to be primarily based on positive feedback from patients. What are the other factors that influence this concept of self as nurse, and how does this concept of self relate to later choice of a clinical specialty? Of special concern is the implication of this finding for the nursing care needs of those patients who rarely give any positive feedback, as in the case of the profoundly mentally retarded, the senile elderly, and the chronically mentally ill. Are there factors in the clinical setting other than positive feedback from patients that nursing students can learn to use as a measure of their competence as a nurse? Does the amount and nature of feedback from clinical instructors have an effect on the students' sense of competence?

Finally, this study demonstrates a methodology that has only rarely been used by researchers in nursing education. Qualitative, naturalistic studies, of which ethnography is just one example, offer detailed descriptions of the areas or contexts of interest. Through the ongoing process of data collection and analysis, the qualitative researcher examines the interrelatedness of many complex and changing variables rather than examining one or two variables in isolation.

The variables of interest are revealed in detailed descriptions which represent the experience of the participants of that social context. Researchers can benefit from broad, naturalistic studies of nursing students and their instructors in the many social contexts where nursing education takes place. The present study provides an example of an approach to qualitative research and the kinds of findings that come from such naturalistic studies.

Use of Findings to Nurture Educators

The detailed descriptions of the student experience of clinical learning, while not directly generalizable to other clinical settings, may serve as a catalyst for clinical instructors to examine their approach to the learner in new ways. Instructors need to examine their ideas about the purposes of the clinical practice experience in nursing education. Is clinical practice time for teaching and learning, or is it for evaluation? One of the strongest implications of this study for nurse educators is the necessity to clearly delineate teaching time and evaluation time. If the line between teaching and evaluation is not clear, the student will view all interaction with the clinical instructor as evaluation. If the students define evaluation as the instructor's role in the clinical practice setting, they will use the strategies outlined in this study to manage the student-instructor interaction in order to look good as a student whenever possible. If faculty provided an evaluation free environment, that is, free of evaluation in the summative sense, it might decrease student stress, increase the learning value of the

student-instructor interaction. This new learning environment might also lead to some alternative ways that the students can learn to feel good about themselves as nurses.

None of the previous studies in nursing education examined student learning in process. This study can serve to link what is known about teacher and learner characteristics with educational outcomes. Instructional methodologies that do not take into consideration the effects of the nursing student perspective are not likely to have the anticipated outcomes. For example, the doing no harm goal served both as a reason for students to attend to a model and as a motivating factor for the student to use that model. Instructional methodologies that are used outside of the clinical setting should take this into account. Learning in the skills lab, unless the students were preparing for the next day's clinical experience, lacked the effect of the do no harm goal to promote the initiation and effectiveness of the learning process. The effects of any instructional methodologies on the learning process will be mediated by the nursing student perspective.

In this study of nursing students' experience of learning in a clinical setting, students were found to have defined a perspective of clinical practice that affected each step of the learning process. The perspective consisted of goals, actions and roles which were interactively defined. The learning process consisted of observing, rehearsing, doing, and evaluating. The steps of learning a clinical skill combined with the nursing student perspective are consistent with the components of observational learning in Bandura's (1977) social learning theory.

APPENDIX A

HORSING PRACTICE III COURSE OUTLINE

<u>Course Number:</u>	NUR 4531
<u>Course Title:</u>	Nursing Process III
<u>Credits:</u>	8 semester hours Clinical practice hours per week: 17 Seminar hours per week: 3 Skills lab hours per week: 3
<u>Placement:</u>	Level II
<u>Faculty:</u>	Assigned Faculty
<u>Prerequisites:</u>	Nurs 3610 II Nursing Process II
<u>Co-requisite:</u>	NUR 4530-- Health Problems I

Course Description: This course is designed to provide students clinical practice in the use of the nursing process with adult medical or surgical and pediatric clients with a variety of health problems.

Course Objectives: Upon completion of Nursing Process III, the student will be able to:

1. Utilize the nursing process by caring for clients with specific health problems in a variety of settings through application of concepts related to:
 - a. The dynamic nature of holistic care.
 - b. The health-disease continuum and continuity of care.
 - c. The pathophysiology of health problems.
2. Coordinate nursing goals and interventions with other therapeutic modalities used by the health care team.
3. Practice according to the legal and ethical constraints of the profession and the agency.
4. Apply principles of leadership and management to ensure quality nursing practice in the delivery of health care.
5. Assume responsibility for professional growth and development.
6. Evaluate research findings and incorporate them into nursing practice.

12. Revise client goals and/or nursing interventions as appropriate, based on evaluation results for selected clients, as evidenced by client record, written nursing care plan, and discussion with instructor.
13. Describe the health-disease continuum concept in relation to the discharge plan for a given client situation as demonstrated by completing discharge summary sheet when appropriate, client and family health teaching, and discussion with instructor.
14. Complete one in-depth case study of a selected client including data base, pathophysiology, nursing diagnoses, goals, interventions, rationale for interventions, evaluation, and discharge planning to the satisfaction of the instructor.

Teaching Methods

Supervised clinical practice, simulation experiences, seminar discussion, audiovisual materials, and individual conferences.

Clinical Evaluation

1. Case Study	10%
2. Clinical Project	10%
3. Clinical performance (clinical evaluation tool)	50%
4. Clinical skills examination	pass/fail

Grading

The case study will be completed on a client in the medical or surgical rotation and graded by the medical or surgical faculty member.

The clinical project may be completed in either the medical/surgical rotation or pediatric rotation. It will be graded by the appropriate faculty member.

The clinical evaluation tool will be completed jointly by the medical or surgical instructor and pediatric instructor at the end of the semester. However, at any time during the semester that the faculty assessed the student to be consistently unsafe in the clinical area, the student will not be allowed to continue in the clinical area until the deficits are corrected.

The student must pass the clinical skills examination to receive a passing grade for this course. The student will be given one retake to demonstrate mastery if he fails the first time. The student will perform the skill(s) he failed plus one additional skill. If the student fails the second time, he will receive a failing grade for the course.

Learning Activities

1. Attend clinical and clinical seminar at designated times.
2. Complete working care plans on assigned clients every week. The student should also be prepared to discuss the data base, pathophysiology, and rationale for interventions although it is not required that these be written each week.
3. Complete one case study. The student must have the client he selects approved by the faculty.
4. Complete one clinical project. This project may be a patient or faculty teaching project, a teaching project for peers, seminar staff, a research project, or any other project approved by the faculty member. All projects must be approved by the faculty.
5. Attend skills lab 2 hours/week. Notes that the skills lab is open will be posted.
6. Attend alternative learning experiences as assigned and complete written assignments.
7. Incorporate research articles into working care plans, case study, clinical projects and presentations and seminar.
8. Complete clinical log each week as indicated by each individual instructor.

Student Preparation for Clinical-

Thorough knowledge should be gained prior to the beginning of the actual care of the client. Completion of the following activities listed below will assist the student in accomplishing this goal.

It is the student's responsibility to initiate student-instructor contact during each clinical experience to demonstrate the quality of the clinical preparation. Evidence of the student's accountability for clinical preparation will be documented in the student's evaluation for that day.

1. Familiarization of the clinical area,
2. Read current hospital chart and old medical records of the clients assigned.
3. Visit with the client, and significant others if possible, assessing the total client situation.
4. Be familiar with each medication the client is receiving.

5. Develop working nursing care plan according to the format, and be prepared to implement the plan.
6. Revise care plans as the client status changes.
7. Complete and submit a diagnostic procedure report whenever the client assigned is scheduled for a procedure. Be prepared to perform all nursing procedures required for the diagnostic procedure ordered.
8. Actual skills lab to practice skills required in the care of your clients prior to clinical time.

General Information:

Activities: The student is required to participate in all scheduled learning activities, including clinical experience, skills lab and all seminars.

Preparation: The student is expected to be prepared for all clinical and laboratory experiences. This preparation will include gathering all client data sufficient for a preliminary assessment, including medication documentation and formulating a prioritized nursing problem list for ascribing nursing diagnoses, and developing a nursing care plan. This preparation should be done prior to the scheduled clinical experience.

Any student who is not prepared for the clinical experience by meeting the above stated criteria may not be allowed to participate in the clinical session, and will receive an unsatisfactory clinical grade for that day.

Absence: The student is responsible for notifying the clinical instructor and the clinical area at least one hour prior to all scheduled clinical activities if the student will be late or absent for any reason. Absences for the clinical session will be made up at the discretion of the faculty.

Dress: The student is required to dress appropriately at all times when required to be in the clinical area: white dress or white pants suit, or lab pants with a tunic top, name pin and collage of Nursing school (the patches the top of the left chest), white comfortable shoes and gaiters or white knee high socks for females. A white color sweater may be worn if necessary. Long hair must be pulled back and secured. In general, the student dress should conform to the dress guidelines stipulated by the clinical agency.

Assignments	Clinical assignments will be made by faculty responsible for the clinical rotation. Assignment sheets will be posted at designated times and places.
Evaluation	The student will have an evaluation conference every 6 weeks with his/her current instructor. The student is required to perform a complete self-evaluation of his/her clinical performance at the end of the semester. The completed self-evaluation must be brought to the final evaluation conference. The student should include specific rationale for each section of the evaluation tool completed.
Alternate Clinical Experiences	Alternate clinical experiences will be arranged through the clinical instructor for that rotation. Guidelines for student response to the experience will be provided.
Log	One log entry will be submitted weekly. Each log must follow the specific guidelines of the instructor for that rotation.

APPENDIX B
CLINICAL TRIAL/ATION TOOL

Guidelines for Clinical Performance Evaluation in Senior Level Nursing Courses

These guidelines are designed to aid you in rating students' clinical performance in senior level nursing courses.

The Clinical Performance Evaluation is divided into seven parts, each of which corresponds to one of the seven terminal competencies of the undergraduate program.

At the top of each page are levels of performance for which ratings are assigned. These levels reflect unsatisfactory, satisfactory and outstanding performance. To derive a letter grade, the level of performance is then transferred to a rating of 0, 1, or 2 respectively. A rating of zero represents unsatisfactory performance, one represents satisfactory performance, and two represents outstanding performance.

Under each level of performance, for each of seventeen criteria, are descriptive behaviors designed to guide students and faculty in determining each student's level of competence.

One final rating should be assigned for competencies I, III, IV, V, VI, & VII. Competency II relates to the nursing process and has been subdivided into eleven parts. Each of these parts is to be rated separately.

Simple

1. Select the level of performance which most accurately describes behaviors demonstrated by the student.
2. Assign a rating of zero for unsatisfactory behaviors, one for satisfactory behaviors, and two for outstanding behaviors. It will be necessary to use both behaviors described and the faculty member's professional judgment to arrive at a final rating for each criterion.
3. Circle the final rating of the clinical performance evaluation form.
4. Add final ratings for the seventeen criteria and assign the course grade based on the grading scale.
5. A final rating of zero on any of the seventeen categories means failure of the student to achieve a satisfactory level of performance and results in a failing grade for the course.

88-94	A	73-82	C
75-87	B+	63-72	D+
65-74	B	53-62	D
55-64	C+	43-52	C

1. In a Conceptual Framework, to provide for the utilization of the Nursing Process

Qualitative

Examines one or two components of conceptual framework when asked.

Includes only event pattern behavior to one or two components of conceptual framework when asked.

Looks at behavior (esp. event) only when told to. Looks remaining questions with to look for behavior which illustrates conceptual framework.

Accepts findings or lack of them without questions about its value.

Examines one or two components of conceptual framework in relation to but transactionally and not in relation.

Inflectionary

Examines almost all components of conceptual framework when asked and gives general examples of using it from past experience.

Includes describes (event) pattern behavior to most components of conceptual framework without being told.

Looks at event behaviors related to components of conceptual framework when told.

Questions validity or desirability of event findings.

Examines that if components of conceptual framework in relation but not all of them consistently. Goes to without being mentioned.

Relational

Examines all components of conceptual framework and gives specific examples of using it from past experience when asked.

Includes event behavior to each component of conceptual framework without being asked.

Looks at event behavior for components of conceptual framework independently.

Includes questions about lack of evidence for any component (1-5). Answers are pulled up not from developmental tasks that could be expected.

Examines all major components of conceptual framework in relation to each other plan and address being mentioned.

11. Utilizing the Sampling Process as a Self-Reflective Problem-Solving Method for Providers, Mentors and Mentees Analysis of Individuals, Families, Groups, and Communities

11. A. Collects Data

Identifying

Identifies data sources
committed to serving his data
to collect it.

Wants to properly use data from
various sources. Data not
necessarily or follow through with
secondary resources even after
considerable investment.

Data collected shows frequent
involvement in client's
functional patterns or diagnosis.
Data significant data.

Data not means the clients is
related to the 3 domains -
environmental or developmental
influences. Data not identify
importance of collecting data.
Data also collect functional.

Sampling

Usually follow through with
collecting data specific to the
clinical setting.

Collects event and response data
related to client's signs
diagnosis. Indicates knowledge of
secondary resources but sometimes
needs assistance in seeking them
out for data.

Data collected is generally
relevant to client's diagnosis and
functional patterns. May include
some irrelevant data.

Usually collects some obvious data
is relevant to 3 domains, etc. Can
describe the significance of data
data in dealing with clients
effectively.

Interpreting

Consistently collects routine data
within setting and needs and more
response data without being
assigned.

Looks event and event data related
to knowledge data and relational data
methods to collect data. Indicates
data anticipated when it doesn't
appear. Anticipates data to be
retrieved on clients and predicts
relatives based on other data
collection. Independently
investigation primary and secondary
resources and anticipates potential
need for additional secondary
resources to collect more thorough
assessment.

Consistently collects pertinent
significant data that corresponds
to client's event and potential
problem.

Consistently collects data on
clients appropriately is relevant to
3 domains etc. Anticipates need
for more relevant data is relevant to
these factors.

Unsatisfactory

Does not actively collect data to place client in the satisfaction when assigned.

Does not collect data necessary to actively involve client. After assigned, does not use knowledge base to develop methods to involve client.

Follows data without attempting to prioritize in regard to client's needs, what does prioritize, the order is illogical or unsafe.

Does not use data collection as ongoing process. Will not consider satisfaction in applying as a component of nursing process.

Satisfactory

Collects data to support client's writing on the contract but may need periodic reinforcement to client. May have inaccurate placement or use position as static.

May need guidance in choosing order of data collection in regard to knowledge base. Will reflect this data after assigned or consultation.

Generally prioritizes data collection in regard to client's needs but may need assistance in arranging order or utilizing sequence in a realistic manner.

Usually collects data as an ongoing process but may need frequent assistance in applying completed data collected to nursing process.

Outstanding

Collects accurate data that consistently supports the client's position on the contract. Anticipates changes in client's status that may shift their position on the plan and will immediately collect data to support.

Independently collects data on client's writing throughout base. Anticipates additional data needed and seeks validation on needed data collected and chooses most appropriate methods in regard to client's diagnosis.

Consistently prioritizes data collection in regard to client's needs that are dependent realistically. Anticipates conditions in which priorities would change.

Consistently uses data collection as an ongoing process and anticipates changes in status in regard to previous data collected.

Insufficient

Doesn't verify answers or sources
data on claims according to
knowledge base. May
commit errors in judgment
and/or factuality.

Sometimes interview based on
interviewing data that can be
potentially harmful to client.
Does not think through before
reacting. Occasionally does not
collect data adequate to produce
reasonable decision.

Unhelpful

Usually verify answers data.
May need assistance in
identifying potential errors in
judgment. Some impressions
with practice. May identify
errors as they occur. Will
attempt to correct.

Usually attempts to collect data
before helplessly reacting.
Good patience in determining
depth of responses before
intervening. Can often assume
problem is related to asking open
ended data when asked.

Overreacting

Consistently seeks assistance
needed to understand and
predict potential errors before
they occur and uses methods that
reduce investigation. Isolates
actual strengths and assess
appropriate channels to resolve data.

Consistently seeks out variety of
data and seeks potential outcomes
before intervening. Speculates
potential problem with
insufficient data collected and
negative action assessed.
Incorporates additional data into
each plan and shares with other
health professionals.

11. 4. Analyzes Data Collected

Insufficient

Does not state nursing diagnosis from top or more desirable when appropriate and device.

Timing of nursing diagnosis is not supported by data either is not logical.

Does not state any relationships in data when assigned.

Does not state conclusions from data collected or conclusions are transcribed as evidenced by charting and clinical performance.

Does not state priorities for care based on analysis of data when asked.

Satisfactory

States all devices and any potential diagnoses from all three sources when appropriate.

Consistently states diagnosis with content and logical timing.

Always states device relationship to data independently. Also guidance can state relationship to subject's data.

States conclusions usually supported by sufficient data. Conclusions are usually accurate.

Analyzes data in order to set priorities and sequencing is usually appropriate.

Outstanding

Covers all diagnoses (obvious and potential) consistently.

Consistently states nursing diagnosis with logical and/or complex etiology.

States all relationships to data consistently and independently. Needs validation when necessary.

Conclusions are consistently supported by sufficient data. Conclusions are consistently accurate.

Analyzes data to set priorities and sequencing is consistently appropriate.

11. 6. Formulation Goals

Unsatisfactory

Only states goals related to nursing diagnosis with repeated statements.

Only states goals in terms of client behavior.

Only includes specific criteria for measurement.

Only states long term and short term goals.

Only states multiple goals.

Does not collaborate with patient and/or family in stating goals. Goals are merely individualized.

Satisfactory

Only states goals related to nursing diagnosis with initial statement.

Only states goals in terms of client behaviors with initial statement.

Goals usually include specific criteria for measurement.

Consistently states short term and long term goals when appropriate with initial statement.

Goals are usually realistic based on client's ability, but may be unrealistic in application of complex theory or consideration of environment.

Usually collaborates with client, family or health team members in establishing individualized goals when appropriate.

Outstanding

Consistently and independently states goals related to nursing diagnosis.

Consistently and independently states goals in terms of client behavior.

Consistently states goals which include specific criteria for measurement with initial statement.

Consistently states short term and long term goals when appropriate with initial statement.

Goals are realistic in terms of client's ability, complex theory and client's environment.

Consistently collaborates with client, family or health team members in establishing individualized goals when appropriate.

11. 6. Plan Interventions based on Goals

Individualizing

Plans include interventions appropriate to nursing diagnosis but inappropriate to the individual.

Interventions rarely identified with medical plan of care but do not reflect consideration of medical plan for the specific medical problem.

Interventions mostly goal-related but usually inadequate to achieve goals.

Plans inappropriate to diagnosis identified to nursing diagnosis.

Plans inconsistent with conceptual framework, healthcare health outcomes.

Plans inconsistent with conceptual framework, disease/ disease outcomes.

Standardizing

Plans are appropriate to the nursing diagnosis and mostly appropriate to the individual client's needs.

Interventions are consistent with medical plan of care for the individual.

Interventions consistently adequate, sometimes creative and usually adequate for achieving goals.

Plans consistently appropriate to the domain identified in the nursing diagnosis.

Plans are designed to maximize client's health status, e.g., toward positive movement on the healthcare status continuum.

Begin to recognize potential for change in client's placement on healthcare status continuum and plans are anticipated to prevent or cope with change.

Substandard

Plans are consistently appropriate to risk diagnosis and to the client's individual needs.

Interventions are consistent with medical plan of care for the individual and include plans specifically related to client's order. Do not reflect placement of nursing for client placed on admission triage stage.

Interventions consistently complete, adequate, and frequently creative.

Plans consistently appropriate to the domain identified in the nursing diagnosis.

Plans consistently demonstrate ability to place client on healthcare health continuum and work toward positive movement on health.

Applies knowledge in anticipatory care to avoid negative content on disease/ disease continuum or to preclude positive movement toward disease.

Institutionalizing

Plans consistently include implementation, follow-up or monitoring, and/or evaluation components that are consistently appropriate or necessary for care.

Plans, subject to consideration of client's socioeconomic status, cultural background, or developmental level.

Plans frequently related to work and time, i.e., leaving action and time frame for action.

Time sequence consistently unrealistic for achievement of goals.

Locally includes evaluative criteria for which to measure goal achievement or outcome.

Plans consistently inappropriate for setting in which only is provided, i.e., hospital vs. community.

Sociocentric

Plans interventions for biological, affective, and cognitive domains.

Plans are usually realistic in relation to socioeconomic status and cultural background and developmental level with family involvement.

Plans consistently include specific directions related to work and time.

Time sequence usually appropriate and realistic to achieve goals.

Locally includes evaluative criteria for which to measure goal achievement or outcome.

Plans usually appropriate to setting and begins to be specific to unit, individuals and resources.

Contingency

Plans interventions for 3 domains and with consideration to client's family and community.

Plans are consistently individualized for the client's socioeconomic status, cultural background, and developmental level.

Plans consistently include specific directions related to work and time.

Time sequence consistently appropriate and realistic to achieve goals.

Consistently includes comprehensive evaluative criteria by which to measure goal achievement or outcome.

Plans are consistent with unit plans, guidelines.

11. E. Basic Investigations on Basic Rationality

Unsatisfactory

Rationale frequently inappropriate to serving intervention.

Rationale gives basic reflection of need for specific intervention but lacks depth, trying to explain both ends and means.

Rationale not usually documented as directed.

Rationale not from identifiable resource or resources.

Rationale usually fails to demonstrate application of content presented in serving curriculum

Satisfactory

Rationale is consistently appropriate to support serving intervention.

Rationale supports verb and content of each intervention.

Rationale is consistently documented as directed.

Uses varied references in documenting rationale including research but without statement of the validity of research findings.

Rationale systematically demonstrates application of served class content and readings developed in background material.

Outstanding

Rationale is consistently appropriate to support serving intervention.

Rationale reflects concepts support of specifics of each intervention.

Rationale is consistently documented as directed.

Consistently uses varied references to documentation. Includes research which has been critiqued and assessed as valid.

Rationale reflects ability to apply the conceptual framework to support of related serving intervention.

Rationale reflects ability to integrate knowledge gained in varied courses and/or clinical experience.

Ex. 7. Implementation Plan

Interventionary

Verbally station how time and resources will be organized to implement/complete plan and needs referrals to staff plus appropriate and realistic to time frame of client or client's environment. Agree to create or initiate a client order environment for client with plans. with instructor's help times and within procedure for changing client for care as with.

Implement and complete basic plan activity with frequent guidance from instructor as staff leader supports will be in carrying out technical care and implementing nursing interventions and medical orders.

Does not act appropriately when changes occur to client or situation.

Instructionary

Verbally station/instruction for time and resources will be organized to implement/complete plan during observation and realistic to time frame of client and environment. Usually creates and initiates a client order environment for client. Agree to look at rest of care to client and institution.

Implements and completes basic plan activity with support. Reliance with complete plan from instructor or staff to carry out safely.

Implements changes to client or environment and adapts plan with limited guidance. Can implement independently within with minimal guidance. Is an emergency with call for help, provide first aid or CPR, and provide assistance when help arrives.

Delegating

Implements and client organization of time and resources to implement/complete plan during observation and realistic to time frame for client and environment. Additional time utilized about equally with clients or staff. Always creates and initiates a client order environment for clients. Provides client safe-effective care as appropriate.

Implements and completes both basic and complete plans independently from instructor or staff.

Usually recognizes changes to client or environment and adapts plan accordingly. Can implement appropriate actions. Is an emergency, will call for help, provide first aid or CPR, provide assistance when help arrives, and help to more sophisticated client monitoring as it appropriate.

Deficient/Unsatisfactory

Includes such guidance to students as:
"I am not sure if I am doing it right."
"I don't know if I am doing it right."

With continuous guidance interventions to client's family system or environment. Focus is to develop listening and communication skills with family members as appropriate.

Teaching is not integrated into daily care plan or is not appropriate (e.g., time, setting, content, understanding to client) and no progress is sought. Teaching plans are not consistently implemented.

Any need guidance to recognize client's condition and adapt plan accordingly.

Provides no demonstration of implementation of plan to instructor or staff (e.g., usually seen, scripted, verbally repeated, describes repeated instructions).

Unsatisfactory

Interventions to client's family system are infrequent and/or inappropriate during given time frame with guidance as needed.

Interventions to client's family system are infrequent as part of holistic care. Interventions to client's family or environment often address family problems, is beginning to address and address the relevant process.

Teaching is integrated into client's care; time, setting are usually appropriate and the teaching is related to client's level of understanding. Begins to evaluate client's new level of knowledge.

Recognizes client's condition and adapts plan with minimal guidance.

Usually provides appropriate evidence of implementation of plan to instructor or staff.

Satisfactory

Provides comprehensive care including all 3 domains as appropriate during given time frame.

Interventions to family system or environment independently and appropriately using the relevant process when needed.

Teaching is consistently incorporated into care; time and setting are appropriate and content is related to client's level of understanding. Evaluates client's new level of knowledge and adapts plan accordingly.

Consistently provides appropriate evidence of implementation of plan and adapts plan appropriately.

Consistently provides appropriate evidence of implementation of plan to instructor or staff.

12. 4. Performs Learned Nesting Skills.

Inadequately

Leads the ends of the order correctly but needs 2-3 corrections when stating the steps of the skills. To say what how what why, is, where is it, how to use it, what criterion for "done" is, the only errors are easily given.

Leads unfamiliar orders but say what some content. Does not state how to learn about skill.

Has to be told to read procedure book for new skills and states the plan of action only with help. Aspires a lot of questioning. Questions relate to aspects not previously contacted content.

States only a general answer when asked about previously presented material (i.e., when asked what to look for when asked if getting tired yet, "a reaction") although content was covered in previous classes. Does not attempt to think through new skills.

Satisfactory

Leads the words of the order correctly and states the steps of the skill accurately for most things previously taught in class.

Leads unfamiliar orders. States at least one way to learn about skill. May need reminder to restate understanding of skill.

Leads up new skills to procedure book without being told. States plan of action with one or two directions.

States only a very general answer when asked why skill is being done if it relates to a new situation. Is more specific if content/skill has been covered previously. Uses previous knowledge when questioned. Gives only very superficial answers when asked to anticipate problems or predict consequences with known skills.

Outstanding

Leads the words of the order correctly, states the steps of the skill accurately for most things previously taught in class.

Leads unfamiliar orders and can state plan for task completion. States rationale for most appropriate periods.

Consistently reads procedure book and states without being asked understanding of plan of action. Questions relate to unfamiliar rather than known skills. Compares variety of logical with procedure and questions differences.

Asks questions from faculty about why skill is being done with all known skills and most when asked. Tries to use previous knowledge to figure things out. Predicts or anticipates consequences for possible problems with all known and some unknown skills. Tries even when skill is not known.

Initial/Factory

Tools employed into areas explained and is going to inspect defective products returned.

Attention is focused mostly on skills. Conversation is non-therapeutic or absent.

Does not collect all the equipment needed for exam. Hears and talks through skill before doing it. Has to be told skill is starting.

Handles familiar equipment awkwardly and sometimes incorrectly. Does not figure out defective equipment. Avoids new equipment. Must be told to read instructions or directions.

Does skill in illogical or disorganized sequence that is detrimental to client.

Intermediate

Introduces self to patient and explains plan before bringing equipment in, without guidance.

Is usually detached. Conversation is usually therapeutic but may sometimes be superficial.

Usually collects all equipment. Usually thinks through skill before starting. Not done so at bedside.

Handles familiar equipment smoothly, correctly. Tries to figure out new equipment. Others to try, once shown. May be awkward in handling new equipment. Reads instructions without being told.

Shows skill at the beginning and completes sequence with usual skills.

Advanced

Introduces self to patient and explains plan before bringing equipment in, without guidance. Asks patient if there is anything they should need to do before the procedure starts.

Consistently reveals delicacy and consideration with client. Is a therapeutic way with both old and new or less familiar skills.

Consistently thinks through skill and organizes equipment and self before entering room. Predicts interferences with skill and takes equipment to solve. Is aware of criticism for over-organization.

Handles familiar equipment smoothly, correctly. Able to figure out new equipment. Asks for help with unfamiliar equipment and seeks out new experiences.

Shows skill at the beginning and completes sequence with usual skills and some new ones.

Insightful

Adjusts skill to basis of an error in very direct comment from client. Deals with only a few of the predictable errors and some of the unpredictable.

Does not recognize most device errors and so few device ones. Inquiries help to correct errors.

Notes 2 or more errors during a rotation. Asks safety errors only because of frequent reminders by facility and/or staff.

Ascribes remedying to just equipment any risk time. For frequent questions about what to do to often go and share to get equipment done.

Intelligent

Adjusts skill to device comments of patient. Deals with the predictable errors and may try to deal with the unpredictable.

Recognizes and corrects most device errors and a few less device ones. Has to be reminded 1-2 times within a shift performance to correct self.

Notes no more than one safety error during rotation. Ascribes one or two reminders from facility or staff.

Acts on equipment only most of the time, needs one or two reminders. Comes up with little help.

Intuitive

Adjusts skill to patient's device and safety comments or behavior. Handles predictable events easily; makes decisions about unpredictable events with the evaluation later. Asks for help if device doesn't work.

Recognizes one error and corrects some when they occur. Predicts errors that can arise and takes preventive action.

Notes no more than one safety error in a rotation. Needs no reminders to do safe work.

Closes up and gets on equipment very seldom reminding. Gets others close up.

11. 11 - Evaluation Effectiveness of Plan and Client's Progression toward Stated Goals

Dissatisfactory

Consistently does not collect sufficient data to evaluate client's progression toward goals.

Does not evaluate the client's progress related to goals set in the evaluation criteria for intervention.

Evaluates client outcomes, only when assigned to do so. Does not include evaluation as an ongoing part of nursing process.

Usually identifies when a plan is or is not effective when assigned but does not attempt to analyze the reasons why.

Dissatisfactory does present incorrect and does not improve accuracy of conclusions over time. Does not consistently evaluate conclusions when appropriate.

Satisfactory

Usually collects sufficient clinical data to evaluate client's progression toward goals.

Usually evaluates client's progression toward goals. May not be a systematic, ongoing process to evaluate plan effectiveness.

Usually will evaluate client when assigned and shows some indications that it is an ongoing process.

Usually identifies when plan is or is not effective in achieving goals, but may have analysis in determining reasons. May not always relate effectiveness to goals. Will attempt to analyze reasons for success/failure when asked.

Usually evaluates the client's progression accurately. Will formulate conclusions, sometimes, as previously encountered situations.

Outstanding

Consistently collects adequate subjective and objective data to evaluate client's progress. Includes content and level assessments.

Consistently evaluates effect of plan in terms of client's achievement of goals and uses criteria to guide for assessment.

Consistently and independently evaluates clients as an ongoing part of nursing process.

Consistently identifies effectiveness of a plan toward meeting goals. Uses knowledge base to analyze reasons for success/failure independently.

Evaluates/analyzes at client status consistently accurate. Uses validation when faculty or newly encountered material after research and compares progress with clients.

II. 1. Review Plan

Unsatisfactory

Does not recognize need to modify and revise client care or goals. Action demonstrates inability to "step up and" deal with instructor's assignments. Does not document revisions.

Does not reword priorities or reestablish goals or plan of care even with assistance. Does not document appropriately.

Implements revised/modified plan with assistance from instructor or staff. Implements reworded priorities/reestablished goals with assistance from instructor/ staff.

Satisfactory

Initiates revision of client care or goals based on evaluation with stated assistance from instructor or staff. "Steps up first" analyzing clinical data with some assistance from instructor or staff. Documents revision or modifications.

Revises care assignments to rewording or reestablishing priorities. Initially documents appropriately.

Initially implements revised/ modified plan. Initially implements reworded priorities/ established goals.

Indefinite

Independently initiates modifications or revising of client care based on evaluation. Initiates goals in collaboration with client and health team. "Thinks as first" analyzing clinical data with rare assistance from instructor or staff. Documents revision or modifications as appropriate.

Priorities reworded and reestablished if necessary. Consistently documents appropriately.

Consistently implements revised/ modified plan and reworded priorities/reestablished goals.

21. 2. Reports and Records Nursing Process

Documentation

Barry uses professional language and/or appropriate medical terminology. It noted an error in communication. That case is frequently misquoted or interpreted. Language might be accurate.

Communication is recorded with no errors in grammar.

Writes communication facts separately. May "error" notations on dates or forms, handwriting is illegible.

Completes all agency forms only after being reminded to do so.

Records data frequently or insufficiently. Needs such assistance in organizing data and formulating notes.

Identifies correct placement of data in SOAP/par format with exceptions, but notes errors when data independent.

Substantive

Uses professional language and/or appropriate medical terminology accurately with some errors in spelling and pronunciation.

Communication is recorded with some errors in grammar.

Writes communication notes. Records "error" notations, in notes or forms. May be difficult to read.

Completes all agency forms with being reminded after presentation to the unit.

Records data accurately. May include extraneous data when formulating notes. Notes usually well organized.

Identifies correct placement of data in SOAP/par format. Needs calculation when appropriate.

Outstanding

Uses professional language and/or appropriate medical terminology accurately with some errors in spelling and pronunciation.

Communication is recorded with no errors in grammar.

Writes communication notes. Some "error" notations in notes or forms. Handwriting clearly legible.

Completes all agency forms without being reminded after presentation to the unit. Questions, incomplete forms. Needs to know status data delivered.

Consistently records data accurately. Data are well organized and logical.

Consistently includes all significant data in correct placement in SOAP/par format.

Reporting/entry:

Contributions to handwashing plan only when asked.

Reports significant data only when asked. Usually needs assistance determining appropriate time frame and service to show to report.

Usually ready and/or prepared to report off at end of shift. Report is frequently missing and significant information may have to be recalled.

Sometimes needs reminding to report off when leaving unit.

Monitoring:

Independently contributes to hand/care plan with out being asked. Looks instances when appropriate.

Independently reports significant data without being asked. Goes to watch appropriate time frame. May need assistance identifying appropriate person to show to report.

Consistently prepared to report off at end of shift. Report may contain extraneous information. Significant information referenced.

Reports off without being reminded when leaving unit.

Substanting:

Independently contributes to hand/care plan without being asked. Substantiates when appropriate. Invokes hand/care plan at daily basis. Keeps all information up to date.

Consistently reports significant data to the appropriate person within the appropriate time frame.

Consistently prepared for shift report. Information is succinct, pertinent, and well organized. All significant information substantiated.

Reports off without being reminded when leaving unit. Reports significant information to appropriate person for consideration during absence.

11. 6. Communication with Clients Throughout the Learning Process

Identifying

Does not express self clearly
even with repeated assistance.
Does not initiate either
communication with client who
desires.

Does not understand or
appropriate language and
terminology. Does not alter
view on basis of client's
socialization or developmental
level.

Focuses on self rather than
client; does not analyze
interactions during
communication and focus behavior
concepts even with assistance.
Does not negotiate with client's
prejudgments.

Does not establish rapport,
alliance, or tentative
relationships; may develop
interpersonal relationships
with clients.

Initiating

Doesly expresses self clearly
and age suitable with client.

Language and terminology usually
appropriate for the situation.
Adapts and adjusts according to
changes in client's social status
or in complex situations.
Usually uses knowledge of
client's developmental level and
socialization background in
communicating.

Focuses on client/therapist
interaction process. May need
assistance in utilizing
therapeutic communication.

Usually initiates, sustains, and
terminates therapeutic
relationships with client
and/or with assigned
clients.

Sustaining

Consistently expresses self
clearly. Usually negotiates with
client.

Consistently uses appropriate
language and terminology even when
client's social status has changed
or in complex situations.
Considers individual and
developmental level of client when
communicating.

Consistently analyzes verbal/
client interaction utilizing
therapeutic communication
techniques and insight.

Consistently and independently
initiates, sustains, and
terminates therapeutic
relationships with a variety of
clients even in complex
environments.

Identifying

Blocks student's verbalizations
Desire of one communication
Subject.

Does inappropriate non-verbal
behavior. Does not recognize
significance of one or client's
non-verbal behavior. Does not
modify behavior after
consequence follows.

Identifies but does not develop
plans to deal with client
behavior that is different from
teacher's or unacceptable to
student.

Identify

Facilitates student's
recognition of effect.
Respects appropriateness to event
expressions. Identifies covert
expressions but does not
respond.

Focus of one non-verbal behavior
and how it affects non-verbal
interaction. Analyzes effect of
non-verbal behavior in
verbalizing interactions with
student assistance.

Identifies and seeks assistance
coping with client behavior that
is unacceptable to student.
Identifies and seeks assistance
interactions with client
behavior that is socially
unacceptable.

Optimizing

Facilitates student's
recognition, acceptance overt
and covert messages of effort
and respects appropriateness.

Consistently analyzes one and
client's non-verbal behavior
of good advantage. Respects one
behavior appropriateness.

Consistently and independently
interacts with client behaviors
that are unacceptable to student
and/or socially inappropriate.

III. Functions According to the Legal and Ethical Guidelines of Professional Nursing by Reporting Inappropriate and Quality Nursing Care

<u>Disatisfactory</u>	<u>Satisfactory</u>	<u>Outstanding</u>
Carries out responsibilities for limited aspects of patient care when assigned.	Carries out responsibilities for most aspects of patient care as assigned.	Carries out responsibilities for all aspects of patient care as well as assisting additional assigned responsibilities when appropriate.
Does not maintain confidentiality of client records and information.	Consistently maintains confidentiality of client records and information.	Consistently maintains confidentiality as well as protecting confidentiality when identified by others.
Is unaware of need for patient advocacy.	Identifies and acts as need for patient advocacy in clinical situations with guidance.	Identifies and acts as need for patient advocacy in diverse and subtle situations.
Does not report errors when recognized.	Reports all errors and initiates corrective action proceedings with guidance.	Reports all errors and initiates corrective action proceedings normally with minimal supervision.
Does not function within realm of legal restrictions when with repeated clients/units.	Functions within realm of legal restrictions independently, consistent my position client interactions.	Functions within realm of legal restrictions independently recognizes violations of legal restrictions.
Inappropriately provides care using system with patients (i.e., religion, ethnic, sex) despite guidance.	Uses guidance to accept belief's values or behavior when different from him. Identifies own ethical dilemma.	Accepts most patient values or behavior with guidance. Suspicion ethical dilemma and seeks help with resolution.

13. Engages in Collaborative Relationships with Parents/Colleagues and other Professionals in Caring for the Health Care

Unsatisfactory

Consistently fails to recognize need for collaboration with other health professionals.

Does inappropriate and/or ineffective communication skills in dealing with other professionals.

Does not work as team with peers when asked.

Reluctant to share learned information with peers. Does not work effectively in communication in sector or hospital etc.

Engaged are used for collaboration with nursing staff but with tendency to keep up. Collaboration limited to areas which given specific direction.

Satisfactory

Usually recognizes need to collaborate with other health disciplines and seeks guidance as necessary to identify appropriate resources.

Does appropriate effective communication skills in dealing with other professionals with some family patients.

Gives assistance to peers in providing patient care when asked and sometimes goes free time to clinical area to assist peers' needs and offer help when appropriate.

Shares his knowledge or skills with peers when specifically asked to and usually communicates accurately and clearly.

Reluctantly and consistently collaborates with his supervisor for student's assigned clients. Sometimes consults with professionals other than nursing.

Outstanding

Consistently recognizes need to collaborate with other professionals in providing patient care and seeks guidance to identify most appropriate resources.

Does effective and appropriate communication skills in dealing with other professionals without patient or following by faculty.

Consistently goes free time to clinical area to assist peers' needs, for assistance and offer help when appropriate.

Reluctantly shares his knowledge or skills with peers. Communication are accurate and clear.

Independently collaborates and consults with nursing staff and a variety of health professionals when appropriate.

F. Apply the Principles of Leadership and Management Theory to Issues Responsible and Accountable Nursing Care

Insatisfactory

Does not identify those of authority in college or agency as an organization or system for assessing nursing practice appropriately.

Does not assume responsibility for assigned clients. Fails to seek assistance when needed.

Unsatisfactory

Consistently fails to direct others in caring for assigned clients. Accepts frequent supervision to assure safe care for clients.

Oversees faculty expectations for assigned care. Does not demonstrate knowledge of self-reliance in providing patient care.

Does not organize time and resources for care of more than one client. Usually does not complete tasks in allotted time.

Satisfactory

Uses knowledge of organizational structure to facilitate care of 1-2 clients in complex situations. Formulation system to obtain resources.

Sometimes shows responsibility for care of patients other than his/her assigned, i.e., may seek help, do vital signs etc., if requested by staff.

With minimal supervision gives care to job clients in complex situations.

Plans care for clients utilizing self-reliance when seeking assistance.

Organizes time and resources in caring for 1-2 patients in complex environments or when complex health problems arise without supervision. May have difficulty completing tasks in allotted time.

Outstanding

Efficiently uses knowledge of organizational and system to deliver health care to groups of clients in complex systems.

Independently takes responsibility as part of unit staff. Seeks opportunities to assist in unit activities.

When appropriate, independently coordinates and delegates care of groups of clients. Gives clear, concise directions.

Independently and voluntarily initiates or directs complex activities other than her assigned care.

Independently organizes time and resources efficiently in caring for groups of clients with complex health problems and/or in complex environments. Tasks are completed on time and timing is appropriate.

Dissatisfactory

Expects incorporation with changes by client or environment, does not identify obvious problems in client, system, or environment.

May retreat from conflict—act evasively and/or avoid any interaction with patients, peers, faculty, or staff.

Satisfactory

Asks clients to accept to planned change. Identifies need for change in people, processes or people who care delivery system. May identify need plan or inappropriate initiation.

Recognizes conflict situations and usually finds solutions in dealing with same.

Outstanding

Identifies need for change and may develop plan, anticipates hidden problems, to initiate realistic system changes and adapt to planned change.

Recognizes conflict situations and deals appropriately with same, independently using conflict strategy.

31. Assess Responsibility for Professional Growth and Development to Ensure Responsibly and Accountably Learning Care

Unsatisfactory

With guidance looks up information to assess learner's self-conduct.

Rarely observes and learning needs.

Needs to be directed when to seek guidance.

Aspects constructive criticism and modifies behavior accordingly.

In context, from clinical scenario and/or does not participate effectively.

Begins to identify major strengths.

Does not speak up or take appropriate action as patient's safety is at risk situation.

Active inappropriate to clinical experience without instructor present.

Satisfactory

Looks up information independently to assess learner.

Interacts on learning needs, but educational activities not always appropriate to learner needs.

Rarely seeks guidance and direction when appropriate.

Qualifies behavior based on constructive criticism.

Aspects clinical scenario, is attentive and participates when asked or requested.

Begins to identify major strengths and weaknesses and engages in self-reflection.

Aspects self by speaking up to discuss situation and begins to in less critical situations.

Active consistently appropriate in area without instructor present.

Outstanding

Looks up information independently to assess other than the self textbook.

Interacts on learning needs and seeks out educational activities that are appropriate to learner needs.

Consistently seeks out guidance and direction when appropriate after soliciting one response.

Critiques on action and self from behavior.

Aspects clinical scenario, is attentive and voluntarily makes relevant contributions.

Consistently is able to identify both strengths and weakness and is realistic in self-reflection.

Aspects self by speaking up to seek patient safety situations.

Active consistently appropriate in area without instructor present.

8.11. Evaluation and Implementation Research: Practice vs. Beliefs

Quality Health Care

Descriptive

Cites references in APA style with using errors in content references.

Does not select, integrate with cards on research related to nursing claim specifically to the nursing area.

Does not connect research findings

Does not question the results of research findings.

Justifying

Cites references in APA style without errors for content references.

Focuses on assigned critiques or findings and questions incorporates research findings into care plans and patient care.

Only focus is research critiques and assigned

Questions analysis and questions the results of nursing research.

Defending

Cites all references in APA style with errors for content and content references.

Consistently seeks out nursing research findings as part of the planning of nursing care and incorporates these findings into the planning and implementation of nursing care.

Consistently synthesizes results of research findings to plans and actions in professional nursing.

Frequently analyzes and questions the results of nursing research. Identifies areas in which research activity might generate new knowledge.

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BIOGRAPHICAL SKETCH

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I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.


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